VA INDIVIDUAL PLAN ENROLLMENT FORM

DentalSelect

Use the Individual Enrollment Form to collect first time subscriber and dependent information.
For existing member changes, please use the Change Form.

Choose Your Plan

☐ Coinsurance (Platinum Network) ☐ Coinsurance Plus (Platinum Network)

☑ EyeMed Discount Vision Program Included

Subscriber Details

SSN	Date of Birth (MM/DD/YYYY)	
First Name	M.I.	Last Name
Address		
City	State	Zip Code
Phone #		Gender ☐ Male ☐ Female
Email Address		
Requested Effective Date (MM/DD/YYYY)		
Agent Name		
Agent Number	Agent Phone Number	

Dependent Details

Spouse Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN	Relationship	Date of Birth

For additional dependents, please attach separate sheet.

Billing Infomation (Choose either Checking/Savings or Credit Card Payment)

Billing Period: ☐ Monthly (Withdrawn on the 15th or next 2 business days)
☐ Annual (Check or Credit Card)

Checking or Savings

☐ Checking Account (Include Voided Check) ☐ Savings Account (Include Deposit Slip)

Financial Institution:

Routing Number:

Account Number:

Credit Card Payment

☐ VISA ☐ MASTERCARD

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Account Holder Name:

Account Holder Signature: Date:

Have you been covered under another dental policy within the last 30 days? ☐ Yes ☐ No
Will this policy replace any other policy currently in force? ☐ Yes ☐ No
If yes: 1. Please provide an Evidence of Coverage Letter, with dates of coverage, from your prior carrier if you are eligible for takeover benefits. 2. Please complete the attached Replacement form.

Authorization of Coverage

I wish to enroll in the plan I have selected. I authorize and agree to account deduction of the required premium. I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief.

This authorization will appear on my statement as Dental Select, and remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution, per their cancellation guidelines, before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. Please direct billing inquiries to Dental Select, 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, UT 84070. I have read and understand the statements above pertaining to the billing option.

WARNING: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

In the event there are insufficient funds when a draft is charged to my account, I agree to pay $25 NSF Fee.

CANCELLATION BY INSURED:

You may cancel this policy at any time by written notice delivered or mailed to Us effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, We will return promptly the unearned portion of any premium paid. If You cancel, the earned premium shall be computed pro rata as of the date the termination became effective. If We cancel, the earned premium shall be computed pro rata as of the date the termination became effective. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

CANCELLATION BY COMPANY:

The Company may cancel this policy at any time by written notice delivered to the Insured, or mailed to his last address as shown by the records of the Company, no less than 31 days thereafter, the cancellation shall be effective. In the event of cancellation, the Company will return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Signature: Date:

The policy provides limited benefits. Review your policy carefully.

Please fill out and return this Enrollment Form with your payment to:

Enrollment Department
PO Box 26203
Salt Lake City, UT 84126

Phone: 800-999-9789
Fax: 888-998-8711
dentalselect.com

Dental Plan Covered Services And Limitations

DentalSelect

COVERED SERVICES:

1. routine examinations and cleanings – 2 per calendar year (in conjunction with all other exams);
2. topical fluoride (up to age 15) – 1 every 12 months;
3. periapical x-rays;
4. occlusal x-ray – 1 every 24 months;
5. space maintainers (up to age 16) – to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment;
6. sealants on permanent molars (up to age 16) – every 36 months.
7. bitewings x-rays (age 2 and over) – 8 total per year;
8. oral surgery – simple extraction of teeth; frenectomy, incision and drainage of intraoral abscess; extraction of impacted teeth; surgical exposure of teeth; alveolectomy; alveoplasty; excision of pericoronal gingiva, exostosis, hyperplastic tissue; reimplantation and repositioning of natural tooth;
9. non-routine exams and consultations - 2 per year (in conjunction with all other exams);
10. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (certain exclusions apply, see Expenses Not Covered).
11. panoramic (age 6 & over) or full mouth series x-rays (age 11 & over) – 1 every 60 months;
12. crowns, onlays – once per 60-month period per tooth (age restrictions may apply) (excludes crown build-up, posts and pins);
13. inlays – (benefit shall equal an amalgam (silver) restoration for the same number of surfaces. If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's payment for the covered benefit and the dentist's submitted fee, plus any coinsurance for the covered benefit);
14. recementing inlays, crowns and bridges;
15. repair of dentures or bridges;
16. general anesthesia, including intravenous sedation:
    a. age 7 & under – once per calendar year, up to $150;
    b. age 8 & over – for the extraction of impacted teeth, based on necessity and not for anxiety management, up to $150 per year;
17. dentures, partials, bridges (age 16 & over) – once per 60 months;
18. endodontic treatment: root canal therapy (age restrictions apply); pulpotomy; pulpal therapy; apicoectomy; apexification/recalcification; root amputation; hemisection; intentional reimplantation; retrograde fillings;
19. periodontic services: a. perio maintenance - 2 per year (in lieu of preventive cleaning);
    b. root scaling and planing (once per quadrant of mouth in any 36-month period);
    c. gingivectomy, gingival curettage;
    d. osseous surgery including flap entry and closure;
    e. pedical or free soft tissue grafts;
    f. full mouth debridement - once per lifetime (limited services available on same date of service);
20. addition of teeth to existing partial denture;
21. relining or rebasing of existing removable dentures - 1 per 24 months;
22. occlusal guards for bruxism only - 1 per 24 months;
23. supported fixed and removable prosthetic (crowns, bridges, partials, dentures) – a restoration that is retained, supported and stabilized by an implant – (This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility);
24. stainless steel crowns - 1 per 24 months;
25. teeth whitening (age 16 and older; external bleaching when performed in the Dentist's office) – up to $100 every 2 years. (Covered on select plan options)

Dental Plan Covered Services And Limitations

DentalSelect

If your plan includes orthodontia benefits, the following services are covered:

ORTHODONTIA SERVICES:
Appliance therapy:

1. **diagnostic records – (cephalometric film, panoramic or full mouth x-rays, diagnostic casts, diagnostic photographs.)**
2. **removable, fixed or cemented appliance for orthodontic treatment including impressions, installations, & adjustments while covered under the plan.**

LIMITATIONS:

1. **Covered Dental Expenses for appliances, restorations, or procedures to do any of the following.**
   a. Alter vertical dimension.
   b. Restore or maintain occlusion.
   c. Splint or replace tooth structure lost as a result of abrasion or attrition.
2. **Covered Dental Expenses for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.**
3. **Covered Dental Expenses to replace lost or stolen appliances.**
4. **Covered Dental Expenses for any treatment which is for cosmetic purposes.**
5. **Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)**
6. **Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision.**
7. **Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of employment.**
8. **Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.**
9. **Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.**
10. **Covered Dental Expenses because of war or any act of war, declared or not.**

If your plan includes orthodontia benefits, the following limitations apply:

ORTHODONTIA LIMITATIONS:
Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. **for a Program begun on or after the Insured's 19th birthday.**
2. **for a Program begun before the Insured became covered under this section.**
3. **if the Insured's insurance under this section terminates.**
4. **for which the Insured is entitled to benefits under any workers' compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.**
5. **for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.**
6. **for services not required for Necessary care and treatment or not within the generally accepted parameters of care.**
7. **because of war or any act of war, declared or not.**
8. **to replace lost or stolen appliances.**

PRE-EXISTING CONDITIONS LIMITATIONS:
Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

No claim for loss incurred or disability (as defined in the policy) that starts after one year from the date of issue of this policy will be reduced or denied because of a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

Regulatory Notes

DentalSelect

Review your policy carefully

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.