DELTA DENTAL

Health & Counseling Center
UNIVERSITY OF DENVER

Group #8940
2024-2025 Delta Dental Enrollment Form

Check all that Apply: ☐ New Dental Enrollment ☐ New Vision Enrollment

Student Information

Last Name:			DU Student ID #:
First Name:			Date of Birth (mm/dd/yyyy):
U.S. Mailing Address:			☐ Male ☐ Female
City:	State:	Zip Code:	Local Phone #:
DU email address:			

Monthly rate for Student Only coverage:
Dental Plan = $29.80 / Vision Plan = $10.10

Circle coverage term and provide banking information below. If any student does not enroll when first eligible for benefits, the next opportunity to enroll will be for the following Fall Annual Open Enrollment Period.

PLEASE NOTE, EFFECTIVE AS OF YOUR APPLICABLE (RE)ENROLLMENT DATE: *Delta Dental of Colorado will leave your enrollment open-ended. You may carry this coverage with you, if you choose, beyond your time as a DU Student member. However, **you will need to contact Delta Dental of Colorado's Individual Admin team (see info below) to cancel your coverage**.*

Law Students	Quarter Students
Enrollment Period: Aug 1st – Aug 31st *Effective Date: August 1st, 2024*	Enrollment Period: Sept 1st – Sept 30th *Effective Date: September 1st, 2024*
Name on Account: **Name of Banking Institution:**	**Account Number:** **Routing Number:**

Automatic Premium Payment Agreement

I hereby authorize Delta Dental of Colorado to initiate debit entries to my checking or savings account, as indicated above. I acknowledge that payment for the applicable enrollment period will be deducted from my account each month I remain enrolled. If the charge is declined for any reason, Delta Dental will attempt to charge me again the following month. If the charge is still declined, I understand that my coverage will be terminated for nonpayment as of the end of the month for which premium was last paid.

This authorization is to remain in full force and effect until Delta Dental of Colorado receives thirty (30) days written notice from me of its cancellation. The notification must be sent to Delta Dental of Colorado,

Attn: Individual Admin, PO Box 5468, Denver, CO 80217-5468, via email to individual@ddpco.com, or call 877.516.6512.

Enrollment Form must be received at: The DU Health & Counseling Center, 2240 E Buchtel Blvd, 3N, Denver, CO 80208 • Phone 303.871.2205 • Fax 303.871.4242 • email insurance@hcc.du.edu

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

Signature of Authorized Bank User:	**Date:**