Delta Dental of Kansas Community Benefit Plan

Agency Confirmation

Please confirm the individual(s) applying meets the eligiblity requirements as set-forth below. Also, provide your contact information.

Elisha Satterfield with United Way will verify eligibility and notify the agency contact of approval/denial.

Agency Contact

Contact Name: _____ Agency Name:_____

Phone Number: _____ Email Address: _____

Address: _____ City: _____, Kansas ZIP: _____

Eligibility

☐ Family Income: Less than or equal to 250% of the federal poverty line. (Attach income verification.)

☐ Employment: Head of household is employed. Include information on the Enrollment Form.

☐ Lack of Dental Insurance: Confirmation individual/family does not have access to dental insurance by more traditional means (e.g. employer-supplied insurance, eligibility as a dependent).

Please submit this completed form along with

- ☐ Income Verification
- ☐ Enrollment Form
- ☐ Consent to Release Information Form

to United Way of the Plains:
dental@unitedwayplains.org or fax to 316.267.0937

Delta Dental of Kansas Community Benefit Plan Enrollment/Change Form (Please keep a copy for your records.)

Choose One:

☐ New Application of Coverage ☐ Change Authorization

SECTION 1: APPLICANT INFORMATION (Please type or print legibly.)

☐ Add
☐ Terminate

Employer Name: (Please do not abbreviate.) _____

Applicant Name: (First, Middle Initial, Last) _____

Social Security/ID Number: _____

Home Address: _____ City: _____ State: _____ ZIP: _____ Birth Date: (mm/dd/yy) _____

Email Address: _____

Phone Number: _____

By providing your email address, you agree to receive benefit information, including explanation of benefits online. We value your privacy and use a variety of security measures to protect your personal information. Your email will not be sold or used in any way except for Delta Dental communications. You may change your consent at any time, or request paper documents, by going to the Member Account section of our website. There are no conditions, consequences or fees for withdrawing your consent. You have the right to receive your documents in paper form. If you receive electronic documents, you will need access to hardware and software that supports the latest 2 major browser versions of the following (Chrome, Firefox, Safari and or Internet Explorer 11 or above). Additionally, either your web browser or a suitable plugin for opening a file in portable document format such as Adobe Reader is required. You may update your electronic contact information by calling Customer Service at 800.234.3375, emailing moreinfo@deltadentalks.com or logging into the Member Account at www.deltadentalks.com.

☐ Single
☐ Married

Effective Date: (mm/dd/yy) _____

Type of Medical Coverage:

☐ Single ☐ Married

SECTION 2: DEPENDENT INFORMATION (List ONLY eligible family members to be enrolled or affected by change.)

Action	Effective Date (MM/DD/YY)	Spouse Name (First, Middle Initial, Last)	Birth Date (MM/DD/YY)
☐ Add ☐ Terminate			

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits.

Action	Effective Date (MM/DD/YY)	Dependent Name (First, Middle Initial, Last)	Birth Date (MM/DD/YY)
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			
☐ Add ☐ Terminate			

SECTION 3: CHANGES (Please mark all appropriate boxes that apply to change[s] you wish to make.)

DELTA DENTAL OF KANSAS MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT.

Date of Event: _____ Name Change: From: _____ To: _____

☐ Marriage ☐ Divorce ☐ Loss of Coverage ☐ Adoption/Legal Custody of Child ☐ Other: _____

SECTION 4: PATIENT RESPONSIBILITIES & AUTHORIZATION/SIGNATURE

I attest that the information that I have provided is true and accurate. I understand and agree that if accepted into the program I will make an appointment with an in-network dentist, show up for all scheduled appointments, pay for any deductibles and co-payments and will keep family information updated on a timely basis (within 30 days of the event). I hereby apply for dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature: _____ Date: _____

Delta Dental of Kansas
P.O. Box 789769 Wichita, KS 67278-9769

800.234.3375 | DeltaDentalKS.com

Revision Date 10/2020

Delta Dental of Kansas Community Benefit Plan

Consent to Release Information

I attest that the information that I have provided is true and accurate. I understand that my information is electronically tracked in order to assess my program eligibility and for service coordination. The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and payment of services.

I understand that my information (demographic information, eligibility for services/referral information and/or presence in program), and that of the accompanying members of my household, may be shared among providers in order to provide case coordination and/or to expedite my access to needed services and resources. This information may be provided to providers by phone, email and/or written form in order to process a referral and/or secure payment to the correct account. My signature indicates that an agency representative has answered any questions I had about my privacy concerns.

This authorization for release of information is valid for three years from date of signature and is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification in writing. To revoke my permission, I understand I am required to provide this agency a written and signed statement that includes the date my permission was revoked. I further understand that revoking permission to share said information may directly affect my ability to remain in the program.

Name (print): _____ Date: _____

Signature: _____ Date: _____