



Apply Now

- When completing the health history application, try to answer all medical questions with as much detail as possible. Don't worry about leaving anything blank – we will review your application upon receipt and let you know if you missed anything.
- Keep in mind the underwriting process can take up to six weeks. If the underwriter requests medical records, the decision could take longer (up to 60 days). If you need coverage right away, call us or visit our website to sign up for short-term medical insurance (coverage can start as early as midnight tonight).
- Please review the following chart for payment details:

	MEDICA	MCHA	BLUE CROSS	HEALTH PARTNERS
1 st Month's Premium required with application	✓	✓	✓	
Automatic withdrawal required for monthly payment	✓	✓	✓	✓

**Checks must be written from a personal account; however, there are exceptions to this rule. Please contact an InsuranceSmart representative for details. All checks are payable to the insurance carrier NOT InsuranceSmart.*

- Sign and date application. Applications must be received by the home office of the insurance company within 15 days of the signature date.
- Return the application to:

InsuranceSmart

9220 Bass Lake Rd, Suite 300

New Hope, MN 55428

Fax 763-577-0358 (HealthPartners applications may be received via fax)

We will send a confirmation notice upon receipt of your application. Do not cancel your existing medical policy until you have verification that your new policy has been approved. Should you be declined coverage, you may qualify for the Minnesota Comprehensive Health Association (MCHA) Plan. Please contact an InsuranceSmart representative for more details.

We look forward to servicing your insurance needs. Please don't hesitate to contact us at 763-550-0638 or 800-645-6920 with any questions or concerns you may have.



9220 Bass Lake Road, Ste 300 – New Hope, MN 55428

763-550-0638 or 800-645-6920 Fax 763-577-0358

www.InsuranceSmartOnline.com ■ MN Lic #IA-20018362

Dental plan coverage for Aware Care members

Enrollment application

Brought to you by Delta Dental® Plan of Minnesota

PART A – SUBSCRIBER INFORMATION

Subscriber's Name:	Last	First	Middle Initial	Social Security Number / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Day Phone Number	Evening Phone Number	Email Address	Date of Birth / /
Subscriber's Address:	Address		City	State Zip Code
Aware CareSM Member's XZ Number: Refer to your Medical ID Card to obtain number.				
Aware CareSM Agent Information:	Agent Name Ron Grams Jr.		Agent Phone Number 763-550-0638	Agency Code/Number HMM/1133

PART B – ENROLLMENT OPTIONS – Select one plan option and one orthodontic option.

Plan A (\$50 Deductible/\$1250 Plan Maximum) **Plan B** (\$100 Deductible/\$1000 Plan Maximum)
 Yes, I Elect Orthodontic Coverage **No**, I Do Not Elect Orthodontic Coverage

Select Who is To Be Enrolled: Subscriber Only Subscriber + One Dependent Family (Three or More)

Complete this section if you have selected the enrollment option of Subscriber + One Dependent or Family. If more than four family members are being enrolled, attach a list of additional dependent information in the below format. Dependent children age 19-25 must be full-time students to be eligible.

Relationship to Subscriber	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Subscriber's)	Gender		Date of Birth Month/Day/Year	If Age 19-25, Full-Time Student?
		M	F		
Spouse/Domestic Partner		M	F	/ /	
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART C – PAYMENT OPTION INFORMATION – Select one payment option and billing frequency.

A. Direct Withdrawal from Checking Account: Monthly Quarterly Annual
 Name on Checking Account: _____ Bank Name: _____
 Routing Number: _____ Checking Account Number: _____
 The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.

B. Credit Card: Quarterly Annual
 American Express Discover (include CVC2 code from back of card) MasterCard Visa®
 Credit Card Number _____ Exp. Date ____/____/____ Discover CVC2 Code _____
 Name As It Appears On Credit Card _____
 The first premium will be charged immediately. Future premiums will be charged to your account on the 6th business day of each coverage period.

C. Check: Quarterly Annual Send a check with this form payable to Delta Dental Plan of Minnesota. Future premiums will be billed prior to the start of each coverage period. When paying by check or credit card, there is no monthly payment option. If you wish to pay monthly, select the Direct Withdrawal option.

PART D – AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read the information contained in the application and choose to enroll. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. I understand my enrollment is subject to receipt of payment and verification of funds. If I have selected Payment Option A or B, I authorize Delta Dental to withdraw funds from my checking account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made timely I will no longer be eligible for coverage. The start and cancellation dates of my insurance coverage will be determined by Delta Dental Plan of Minnesota. The start date is generally the first day of the month following receipt of the enrollment application. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand that I must enroll for one full year and if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of two years.

Subscriber Signature: _____ **Date:** _____

Send Completed Application To: Individual Dental
 Delta Dental Plan of Minnesota Attn: Enrollment Department
 P.O. Box 330 Minneapolis MN 55440-0330