ENROLLMENT FORM

DeltaVision®

in partnership with VSP® Vision Care

Personal Information Please fill out this form entirely. Incomplete forms will delay your application.

Brown University Retiree – Group 8620	Effective Date (MM/DD/YYYY)		Social Security Number	
First Name	Last Name		Date of Birth (MM/DD/YYYY)	
Street Address / P.O. Box Number		City	State	Zip Code
Email Address		Telephone Number		

Coverage Type & Premium Rates Rates effective thru 12/31/25.
Monthly Premium. (Your coverage is automatically renewed at the end of your coverage period unless you notify us in writing that you wish to cancel coverage).

☐ Individual Dental Coverage $57.89 ☐ Individual Vision Coverage (DeltaVision® – 150 Plus) $6.50

Coverage Action Please select one:

☐ New Enrollee ☐ End Coverage ☐ Change Name/Address/Billing

Enrollment Status

Are you the: ☐ Brown University Retiree ☐ Spouse of Brown University Retiree

Year the Brown University Employee Retired _______________

Method of Payment (See back for details.) *Please check ☑ a payment type and fill in the appropriate information.*

☐ **A. Direct Withdrawal from Bank Account:**

Name on Bank Account:	Type: ☐ Checking ☐ Savings
Bank Name:	Bank Address:
Routing Number:	Bank Account Number:

☐ **B. Credit Card:**

Name: (exactly as it appears on Credit Card)		
Credit Card Type: ☐ MasterCard ☐ Visa ☐ Discover	Credit Card Number:	Expiration Date: (MM/YYYY)

Authorizing Signature:

I certify that all information is true and correct to the best of my knowledge. I understand that the start date and cancellation date of my insurance coverage will be determined by Delta Dental of Rhode Island. I authorize Delta Dental to withdraw funds from my bank account or charge my credit card no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. I understand that if funds/available credit balances are not available or payment is not otherwise timely made, I will no longer be eligible for coverage. I have read and understand the information on both the front and back of this form.

Your signature (Form will not be processed without signature.) Date

Please mail this form to Delta Dental of Rhode Island, P.O. Box 1517, Providence, RI 02901-1517 or email to accountservices@deltadentalri.com

DELTA DENTAL®

BROWN UNIVERSITY RETIREE DENTAL AND VISION PLAN

Please read the following information regarding the plan's eligibility, coverage and payment guidelines.

Eligibility Information
You must be a Brown University Retiree or spouse of a Brown University Retiree to qualify and remain eligible for coverage.

Coverage Type and Premium
You and your spouse are eligible for Delta Dental coverage as individual members. Rates are guaranteed for the entire coverage period. Prior to the end of a coverage period, Delta Dental will mail a notification to you indicating any change in rates.

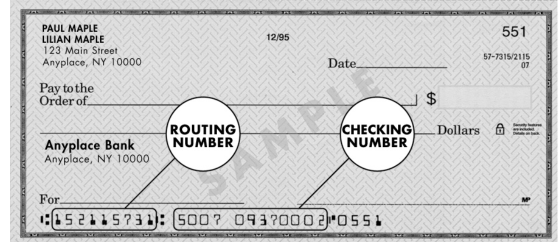
Enrollment and payment of premium is not a guarantee of claim payment. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office and the patient must be covered by a Delta Dental contract on the day services are completed. There are no refunds of premium dollars for this coverage.

Renewal of Coverage
Your coverage is automatically renewed at the end of your coverage period. Your coverage period is from your coverage start date until the end of the calendar year, unless otherwise noted.

If you choose to end your coverage, you must notify us in writing. Cancellation of coverage is effective on the last day of your most recent payment period. **Please Note: If you cancel coverage, you must wait 12 months to reapply. If your new application is accepted, your coverage will begin on January 1 of the following year.** Delta Dental reserves the right to cancel coverage after appropriate notification due to non-payment of premium.

Method of Payment
This is a pre-paid dental insurance plan. Delta Dental offers two convenient payment options.

A.) Direct Withdrawal from Bank Account – Funds will be withdrawn no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. Please use this sample check as a guide when selecting direct withdrawal from your checking account. **Please Note: Transactions that are returned for insufficient funds are subject to a $25 processing fee.**



B.) Credit Card – Your credit card will be charged no more than ten (10) days prior to the start of coverage, and on a monthly basis thereafter. **Please Note: Transactions that are declined are subject to a $25 processing fee.**

IMPORTANT: IF YOUR BILLING INFORMATION CHANGES, YOU MUST UPDATE IT AT DELTADENTALRI.COM.

Authorizing Statement
Please read the authorizing statement on the front of this enrollment form, and sign/date it. Delta Dental cannot process forms without an authorizing signature. You will receive your Subscriber ID card and benefit literature approximately 15 days before your coverage begins.

Please mail this form to Delta Dental of Rhode Island, P.O. Box 1517, Providence, RI 02901-1517 or email to accountservices@deltadentalri.com

Contact us at: 800-843-3582. Visit us at: www.deltadentalri.com

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY
Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.
Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.

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