DELTA DENTAL

GrinWell for You Program Application

Delta Dental of Idaho

ELIGIBILITY

Applicants must meet the following:

- Currently live in Idaho
- Are age 60 or older
- Have a combined household income as shown in the income chart (refer to back page)
- Submit proof of all household income
- Can independently travel to the dental office for treatment within 60 days of acceptance into the program.
- Do not have any current dental benefits

PLEASE NOTE:

- If you have dental insurance and enroll in the program, we are required to remove you from the program immediately and not reimburse your claims.
- If you have preventive dental benefits included in your medical plan without an "opt-out" option, you may still qualify for our program.

APPLICATION PROCESS

1. Complete and sign this application.
2. Include a copy of proof of income:
   - First two pages of Form 1040, U.S. Individual Income Tax Return
   - Your most recent W-2 form
   - A Social Security award letter
   - A pension or an interest statement
3. Include a copy of your dental benefit summary if you have preventive only dental benefits included in your medical plan.
4. Mail or fax application and proof of income to:

Delta Dental of Idaho Community Outreach
555 E Parkcenter Blvd.
Boise, ID 83706
Fax: 208-488-7772

If more than one person in your household is applying, you may send completed applications and forms together

PLEASE PRINT CLEARLY

First Name:	MI:	Last Name:	Date of Birth:
Social Security Number:		Phone Number (with area code):	
Gender: M☐ F☐	Number of people in your household:	Gross Monthly Household Income:	
Mailing Address:	City:	State:	Zip:
Are you enrolled in Medicaid? ☐Yes ☐No		Are you enrolled in Medicare? ☐Yes ☐No	
If yes, do you have Medicare Advantage - Part C ☐Yes* ☐No		**Please include a copy of your dental benefit summary with application*	

I now apply for coverage through the Delta Dental *GrinWell for* You program. I understand Delta Dental's acceptance of the application only applies if I meet the eligibility requirements, including having no other dental benefits, except for preventive dental benefits included in your medical plan without an "opt-out" option.

If accepted, I understand:

- The $1,850 in coverage will be provided only for services available under the *GrinWell for* You program, and **I am responsible for any services I agree to that are not covered by the program. (Please work with your dentist to ensure your services are covered.)**
- The $1,850 in coverage will be provided for a 12-month enrollment period.
- I must visit a participating dentist within 60 days of acceptance into the program.

I hereby certify that the information in this application is true and correct to the best of my knowledge.

APPLICANT SIGNATURE _____ DATE _____

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DELTA DENTAL®

INCOME

Household Income Limits		
Household Size	Gross Yearly Income Limit	Gross Monthly Income Limit
1	$30,578 or less	$2,548 or less
2	$41,198 or less	$3,433 or less
3	$51,818 or less	$4,318 or less
4	$62,438 or less	$5,203 or less
For families/households with more than 4 persons, add $10,620 yearly or $885 monthly, for each additional person.		

REMINDERS

One-year, non-renewable program.

Standard frequency limits apply (i.e., cleaning every 6 months).

Program is designed to cover certain procedures. Work with your dental provider to ensure you receive a covered benefit treatment.

Household size is you, your spouse, and your dependents.

Household income includes all income for the year, such as pay from work, social security benefits, pension income, any disability payments, any rental income, investments, etc.

Proof of household income is required. Please send a copy of the first two pages of your household's most recent Federal tax return.

If your household does not file taxes, you may use the following documents instead:

- Your most recent W-2 form
- A Social Security award letter
- A pension or interest statement

Please report your gross income amount. Gross income is your total income before taxes or deductions.

If the *GrinWell for* You program is full, would you like to be placed on a waiting list?

☐ Yes
☐ No

Where did you hear about our program? _____

For office use only	Eligible Date:	Ineligible Reason:	Date: