DELTA DENTAL®

GrinWell for **You** Program Application

ELIGIBILITY

Applicants must meet the following:

- Currently live in Idaho
- Be 18+ years old
- 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
   - Most recent W-2 form
   - Most recent pay stub
   - Bank statement
   - Award letter from Social Security or Veteran's Affairs
   - Any 1099 form
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 ☐ Other	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 my 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

(Continued)

INCOME

Household Income Limits		
Household Size	Gross Yearly Income Limit	Gross Monthly Income Limit
1	$35,910 or less	$2,993 or less
2	$48,690 or less	$4,058 or less
3	$61,470 or less	$5,123 or less
4	$74,250 or less	$6,188 or less
For families/households with more than 4 persons, add $12,780 yearly or $1,065 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, any disability payments, any rental income, investments, etc.

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

- Most recent W-2 form
- Most recent pay stub
- Bank statement
- Award letter from Social Security or Veteran's Affairs
- Any 1099 form

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?_____

If you have questions please call 1-866-894-3563

Delta Dental of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 356-7586.
注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-(800) 356-7586.

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