DELTA DENTAL®

GrinWell for You Program Application

Delta Dental of Idaho

TO QUALIFY YOU MUST

- Currently live in Idaho.
- Be 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.**
- Be independently mobile and able to travel to dental offices for treatment within 60 days of being accepted into the program.

Not have any current dental benefits PLEASE NOTE: This includes any embedded dental plans.

(If you have dental insurance and enroll in the program, we are required to remove you from the program immediately and claims will not be reimbursed).

TO APPLY

- Complete and sign this application.
- Copy proof of income that applies to you:
  - First two pages of Federal tax return.
  - Your most recent W-2 form.
  - A Social Security award letter.
  - A pension or interest statement.
- Mail 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 **Do you have Medicaid dental benefits?** ☐ Yes ☐ No

APPLICATION

I hereby apply for coverage through the Delta Dental *GrinWell for* You program. I understand that this application will be accepted only if I meet the eligibility requirements, including having no other dental benefits.

If accepted, I understand:

- The $1,250 in coverage will be provided only for services available under the *GrinWell for* You program and that **I am responsible for any services I agree to that are not covered by the program. Work with your dentist to ensure your services are covered.**
- The $1,250 in coverage will be provided for a 12 month enrollment period.
- I must visit a participating dentist within 60 days of being accepted into the program.

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

APPLICANT SIGNATURE _____ DATE _____

(Continued)

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Income Chart

Household Income Limits		
Household Size	Gross Yearly Income Limit	Gross Monthly Income Limit
1	$25,760 or less	$2,147 or less
2	$34,840 or less	$2,903 or less
3	$43,920 or less	$3,660 or less
4	$53,000 or less	$4,417 or less
For families/households with more than 4 persons, add $9,080 yearly or $757 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 are receiving treatment that is a covered benefit.

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 the most recent Federal tax return for your household.

If your household does not file taxes, the following documents can be used 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? _____

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: