Dental Insurance
Pre Enrollment Information Form

Personal Information:

Name: _____ SS# _____

Date of Birth: _____ Male: _____ Female: _____

Address: _____

Depenents: _____ Single or Married: _____

Email: _____ Height: _____ Weight: _____

Have you had Dental coverage within the last 90 days? _____

Dependent Information If Adding To Your Plan:

Spouse: _____ Male/Female: _____ DOB: _____

Child 1: _____ Male/Female: _____ DOB: _____

Child 2: _____ Male/Female: _____ DOB: _____

Child 3: _____ Male/Female: _____ DOB: _____

Plan Options:

		DMO	PPO 1	PPO 2
Premiums are based on individual, zip code and date of birth. More for additional individuals.	Deductible	None	$50 Self	$50 Self
			$150 Family	$150 Family
	Coinsurance	N/A	Preventive: $0	Preventive: $0
			Basic: 20%	Basic: 50%
			Major: 50%	Major: 50%
	Annual Max Benefit	None	$1,250	$1,000
	Copay	$5: Office Visit	N/A	N/A
		$0: Cleaning		
		$0: Exam		
		$0: Diagnostic Imaging:		
		$8: Tooth removeal, simple		
		$19-$63: Filling *(1 surface)*		
		$135-$333: Root canal		
		$347: Complete Dentures Upper		
		$347: Complete Dentures Lower		
		$265-$362: Crowns		
	Monthly Premium	$21-$25	$48-$55	$41-$45

Select Plan $ $ $

Recurring ACH Payment Authorization

You authorize regularly scheduled charges to your checking/savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your bank statement as an "ACH Debit". You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize _____ to charge my
(Full Name) (Merchant's Name)

bank account indicated below for $_____ on the _____ of
(Amount $) (day)

each _____.
(week, month, etc.)

This payment is for _____.
(Description of Goods/Services)

Billing Information

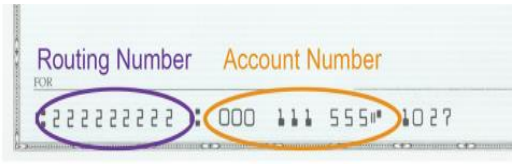
Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Bank Details

☐ Checking ☐ Savings

Account Name _____
Bank Name _____
Account Number _____
Routing Number _____



I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify _____ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that _____ may at its discretion attempt to process the charge again within 30 days, and agree to an additional $_____ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Account Holder's Signature)