



GROUP DENTAL APPLICATION FOR PREFERRED CHOICE (H7)

<u>EMPLOYER INFORMATION</u>	
Company Name _____	
Address _____	
City _____ State _____ Zip _____	
Contact Person _____ Title _____ Phone _____	
Group Enrollment Census _____ = Single _____ Two Party _____ Family _____ Requested Effective Date ____/01/____ <small>(Group must have a minimum of three (3) employees)</small>	
Has your company ever had dental coverage with Healthplex Insurance Company, Dentcare Delivery Systems, Inc. or International Healthcare Services, Inc.? <div style="text-align: center; margin-top: 5px;"> YES <input type="checkbox"/> or NO <input type="checkbox"/> </div>	
PLEASE CHECK BILLING PERIOD: <small>(All monies due will be paid in advance)</small>	
<input type="checkbox"/> MONTHLY	<input type="checkbox"/> QUARTERLY

- NOTES:
1. There is an additional monthly premium of \$10.00 for each family member in excess of five (5).
 2. Coverage for all dependents ends at age 19, or age 23, if full-time student.
 3. Application, enrollment cards and payment must be received by the 15th of the month for coverage to begin on the first of the next month. Exceptions will only be made if the application is received between the 15th and the 25th of the current month and payment is made by certified check, money order, credit card (Visa or Master Charge) or wire transfer.
 4. This application is subject to its acceptance in writing by *Healthplex Insurance Company*.

Please make all remittances payable to: ***Healthplex Insurance Company***
333 Earle Ovington Blvd., Suite # 300,
Uniondale, NY 11553-3608
800-468-0466

SIGNATURE OF OFFICER	TITLE	DATE

BROKER/AGENT: _____

COMPANY: _____

ADDRESS: _____ STATE: _____ ZIP: _____

PHONE: _____ S.S. # /TAX ID #: _____

GROUP #: _____ SALES REP: _____

