NEW YORK CAP*DENT INDIVIDUAL* DENTAL PLAN -- ENROLLMENT CARD

Last Name ____ First Name ____ M.I. ____ M/F ____

Date of Birth ____ Social Security # ____

Address ____

Home Telephone # ____ Office Telephone # ____

City, State, Zip ____

Effective Date ____

DEPENDENTS
(If Two-Party or family coverage is selected)

MARITAL STATUS ( ) Single ( ) Married ( ) Divorced/Widow

Check Relationship

Last Name First M.I. M/F	Spse	Son	Dtr	Birth Date
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /

Plan Selection

[ ] * Cap*Dent* -- (Select Provider)

Please enter the **Dentist's Name and Code Number** from our list of providers:

Dentist Name: ____

Dentist Code: ____

*I understand that Benefits are only available at participating dental offices.

SIGNATURE ____ **DATE** ____

I agree to maintain my enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a twelve month period. When billed annually, a Cancellation fee of $25.00 will be applied to your prorated refund if policy is terminated prior to your expiration date.

NEW YORK CAP*DENT* INDIVIDUAL DENTAL PLAN -- RATE AND PAYMENT FORM

Annual Billing

CapDent (Non-Group)

*Please select **one** option*

[ ] Single $159.00
[ ] Two Party $264.00
[ ] Family $350.00

[ ] Check enclosed in the amount of $ ____ payable to ***Dentcare Delivery Systems, Inc.***

[ ] VISA or MASTERCARD (circle one)

Annual authorization in the amount of $____

Name____ Card #____ Exp. Date____

Signature____ Date ____

MAIL TO:
DENTCARE DELIVERY SYSTEMS, INC.
333 EARLE OVINGTON BLVD, SUITE # 300 UNIONDALE, NY 11553-3608

To enroll on the 1st day of a given month, enrollment materials **must be *received* by the 15th** day of the preceding month.

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

BROKER NAME ____ TAX ID # ____