

NEW YORK CAPDENT INDIVIDUAL DENTAL PLAN ENROLLMENT FORM

MEMBER INFORMATION						
Group Number GCDIY2			Effective Date			
Last Name		First Name		M.I.	SSN/ID #	
Address			City		State	Zip Code
Home Phone		Email Address			Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B. __ __ / __ __ / __ __
MARITAL STATUS						
<input type="checkbox"/> Single <input type="checkbox"/> Domestic Partners <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Widow						
DEPENDENTS TO BE COVERED (Spouse, Domestic Partner & Unmarried Dependent Children up to the end of the month of their 26th birthday)						
			CHECK APPROPRIATE BOX			
Last Name, First Name		M/F	Spouse/D.P.	Son	Daughter	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Daughter	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Daughter	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Daughter	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Daughter	D.O.B.
DENTAL SELECTION - SELECT FROM THE CAPDENT & CAPDENT PLUS PROVIDER DIRECTORY						
Dentist Name		Dentist Site Code		I understand that CapDent In-Network Benefits are only available at participating CapDent dental offices.		
COVERAGE SELECTED - ANNUAL BILLING						
<input type="checkbox"/> Single - \$177.00		<input type="checkbox"/> Two Party - \$300.00		<input type="checkbox"/> Family - \$408.00		
PAYMENT OPTIONS						
<input type="checkbox"/> Check enclosed in the amount of \$_____ payable to Dentcare Delivery Systems, Inc.						
<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover (check one) Annual Authorization in the amount of \$_____						
Name on Card: _____						
Card Number: _____			Exp. Date: _____			
<p>By signing below, I acknowledge that I have read and agree to the terms and conditions on the reverse side.</p> <p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p>						
Signature					Date	
BROKER INFORMATION (IF APPLICABLE)						
Broker Name			SSN/Tax ID#			

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TERMS & CONDITIONS

BENEFITS

I understand that the In-Network benefits insured by Dentcare Delivery Systems, Inc. are only available at participating dental offices and that there are no Out-of-Network benefits.

ENROLLMENT PERIOD

If my application and payment is received between the 1st and 20th day of the month, my coverage will begin on the 1st day of the following month.

If my application and payment is received between the 21st and last day of the month, my coverage will begin on the 1st day of the 2nd month.

PAYMENT AUTHORIZATION

By joining this annual dental plan, I am authorizing Dentcare Delivery Systems, Inc. to bill my credit card for the annual premium.

CANCELLATION POLICY

I agree to maintain enrollment for a minimum of 12 months. If my coverage lapses due to nonpayment of premium, I understand that I cannot re-enroll for a 12-month period. A cancellation fee of \$25 will be applied to the prorated refund should I request termination prior to the renewal date, unless termination reason qualifies for an exemption of said fee.

RENEWAL CONDITIONS

This plan will automatically renew at the end of my membership term on an annual basis unless I notify Dentcare Delivery Systems, Inc. of my request to cancel prior to the renewal date. I understand that my credit card will be automatically charged for the appropriate annual renewal amount.