

International Healthcare Services, Inc.

Group Application

Employer Information				
Company Name				
Address		Apt #	City	State Zip Code
Contact Person		Title	Phone	
Group Enrollment Census			Requested Effective Date	
Single	Two Party	Family	Total Enrollment	Month Day Year
Please Check Billing Period:			Please provide Email Address:	
<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually			_____ @ _____	
Plan Selection				
<input type="checkbox"/> CapDent		<input type="checkbox"/> CapDent Plus		
Minimum Enrollment of 2 Employees		Minimum Enrollment of 3 Employees		
Notes				
1. Coverage for all dependents ends at age 19, or age 25, if full-time student. 2. Application, enrollment cards and payment must be received by the 20th of the month for coverage to begin on the first of the following month. The payment can be made by direct debit, credit card (Visa or MC) or ACH wire. Please make all remittances to: International Healthcare Services, Inc. 3. This application is subject to review and approval by International Healthcare Services, Inc.				
Signature of Officer		Title	Date	
Broker Information				
Broker/Agent				
Company Name				
Address		City	State	Zip Code
Phone Number		S.S.#/Tax ID #		
Healthplex - Official Use Only				
Group Number		Sales Rep		

"PLEASE PRINT OR TYPE ALL INFORMATION"

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