International Healthcare Services, Inc.

International Healthcare Services, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
P 800-468-0466 F 516-227-0582
www.healthplex.com

New Jersey CapDent Individual Dental Plan Enrollment Form

Member Information

Group Number	Effective Date
GCDIJ2	

Last Name	First Name	M.I.	SSN/ID #

Address	City	State	Zip Code

Home Phone	E-mail Address	Gender ☐ M ☐ F	D.O.B.

Other Dental Coverage ☐ Yes ☐ No	Name of other plan (if applicable)

Spouse/Domestic Partner

Last Name, First Name	Gender ☐ M ☐ F	D.O.B.

Dependents To Be Covered - Dependent eligibility is governed by your group's contract. Please see your benefit administrator if you have questions.

Last Name, First Name	Gender ☐ M ☐ F	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

☐ **Single - $153.60** ☐ **Family - $381.60**

Payment Options

☐ Check enclosed in the amount of $ _____ payable to ***International Healthcare Services, Inc.***

☐ Visa ☐ MasterCard ☐ Discover (check one) Annual Authorization in the amount of $ _____

Name on Card: _____

Card Number: _____ Exp. Date: _____

By signing below, I acknowledge that I have read and agree to the terms and conditions on the reverse side.

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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date

Broker Information

Broker Name	SSN/Tax ID #

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Terms & Conditions

Benefits

I understand that the In-Network benefits insured by International Healthcare Services, 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 International Healthcare Services, 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 International Healthcare Services, 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.

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