Administered by

HEALTHPLEX

Send Completed Form to:
Healthplex, Inc.
Attn: Accounting Department
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
E accounting@healthplex.com • F 516-745-0079

Group Payment Form

Group Information

Company Name		Group Number	
Address	City	State	Zip Code
Contact Person	Phone	Email Address	

Payment Options

☐ **Direct Debit** ***Allow 30 days for initial payment processing. First payment must be made by check.***

Routing Number	Account Number
Financial Institution	
Name on Account	

☐ **Credit Card**	**Please Select:** ☐ Visa ☐ MasterCard ☐ Discover
Name on Card (Last, First, M.I.)	Company Name on Card (if applicable)
Card Number	Expiration Date

An additional $5.00 processing fee will be added to any credit card charge.

Authorization

Authorization Agreement for Direct Pay: I hereby authorize International Healthcare Services, Inc. to initiate direct debits from the above-referenced bank account and give International Healthcare Services, Inc. authorization from the group to instruct the financial institution to debit such account for premium payments due. I understand that the monthly direct debit of invoiced amounts will be processed approximately on the 5th business day of each month. I also understand that three (3) business days (in writing) are required to deactivate Direct Pay. Such request can be provided via mail, fax or email.

Authorized Signature	Print Name
Title	Date

Plan Underwritten by:

DENTCARE DELIVERY SYSTEMS, INC.

Administered by

HEALTHPLEX

Send Completed Form to:
Dentcare Delivery Systems, Inc.
Attn: Accounting Department
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
E accounting@healthplex.com • F 516-745-0079

Group Payment Form

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Name on Card (Last, First, M.I.)	Company Name on Card (if applicable)
Card Number	Expiration Date

An additional $5.00 processing fee will be added to any credit card charge.

Authorization

Authorization Agreement for Direct Pay: I hereby authorize Dentcare Delivery Systems, Inc. to initiate direct debits from the above-referenced bank account and give Dentcare Delivery Systems, Inc. authorization from the group to instruct the financial institution to debit such account for premium payments due. I understand that the monthly direct debit of invoiced amounts will be processed approximately on the 5th business day of each month. I also understand that three (3) business days (in writing) are required to deactivate Direct Pay. Such request can be provided via mail, fax or email.

Authorized Signature	Print Name
Title	Date