Plan Underwritten by:

DENTCARE DELIVERY SYSTEMS, INC.

Plan Administered by:

HEALTHPLEX

Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
healthplex.com
P 800-468-0466
F 516-228-9572

New York Select Individual Dental Plan Enrollment Form

Member Information

Group Number GCD4-IND2			Effective Date	
Last Name	First Name	M.I.	SSN	
Address	City		State	Zip Code
Home Phone	Email Address		Gender ☐M ☐F	D.O.B.

Marital Status

☐ Single ☐ Domestic Partners ☐ Married ☐ Divorced/Widow

Spouse/Domestic Partner

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

Dependents To Be Covered - *Unmarried Dependent Children up to the end of the month of their 26th birthday.*

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

Provider Selection - Choose from the Select Provider Network - Required - Visit healthplex.com "Our Dentists"

Dentist Name	Dentist Site Code	***I understand that Select In-Network Benefits are only available at participating Select dental offices.***

Coverage Selected - Annual Billing

☐ Single - $264.00 ☐ Two Party - $432.00 ☐ Family - $618.00

Payment Options

☐ Check enclosed in the amount of $_____ payable to ***Dentcare Delivery Systems, 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date

Broker Information (if applicable)

Broker Name	SSN/Tax ID#

-OVER-

Plan Underwritten by:

DENTCARE DELIVERY SYSTEMS, INC.

Plan Administered by:

HEALTHPLEX

Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
healthplex.com
P 800-468-0466
F 516-228-9572

New York Select Individual Dental Plan Enrollment Form

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.

The Select plan is Affordable Care Act (ACA) compliant and includes the Pediatric Dental Essential Health Benefits, as defined in the ACA for all dependent children under the age of 19.

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.

Termination 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 termination 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 terminate prior to the renewal date. I understand that my credit card will be automatically charged for the appropriate annual renewal amount.

-OVER-