

## Individual Pediatric "Off-Exchange" Enrollment Form

PARENT/RESPONSIBLE ADULT				
Last Name	First Name	M.I.	SSN	
Address		City	State	Zip Code
Home Phone		Email Address		
PEDIATRIC MEMBERS (under age 19)				
Last Name, First Name		SSN	Gender	D.O.B.
Last Name, First Name		SSN	Gender	D.O.B.
Last Name, First Name		SSN	Gender	D.O.B.
PRIMARY CARE DENTIST (PCD) SELECTION				
Please choose one Primary Care Dentist (PCD) from the <b>Exchange Net Provider Network</b> . If no selection is made, a PCD will be assigned nearest your home. To view available dentists in the network, visit <a href="http://healthplex.com">healthplex.com</a> and select "Our Dentists" then "New York State Health Exchange".				
Dentist Name		Dentist Site Code		
PAYMENT OPTIONS (Please note: Region is based on domicile of covered child).				
<b>*Region</b>	<b>Number of Members</b>	<b>Total</b>	<b>Number of Members</b>	<b>Total</b>
Albany	Annual Premium: \$250.20 x	<input type="text"/> = <input type="text"/>	or Monthly Premium: \$20.85 x	<input type="text"/> = <input type="text"/>
Buffalo, Mid-Hudson, Rochester, Syracuse, and Utica	Annual Premium: \$190.80 x	<input type="text"/> = <input type="text"/>	or Monthly Premium: \$15.90 x	<input type="text"/> = <input type="text"/>
NYC and Long Island	Annual Premium: \$133.80 x	<input type="text"/> = <input type="text"/>	or Monthly Premium: \$11.15 x	<input type="text"/> = <input type="text"/>
<b>*Note: Additional region information on reverse side.</b>		<b>Recurring monthly option only available if paying by credit card.</b>		
<b>Payment Options:</b>				
<input type="checkbox"/> Check enclosed in the amount of \$ _____ payable to Healthplex Insurance Company.				
or				
<input type="checkbox"/> Credit/Debit card - initial amount authorized \$ _____. Authorize Monthly Recurring Payment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover (check one)				
Name on Card: _____				
Card Number: _____			Exp. Date: _____	
By signing below, I acknowledge that I have read and agree to the terms and conditions on this form.				
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#		
Group Number	Effective Date	Internal Sales Rep		

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### TERMS & CONDITIONS

#### Benefits

I understand that the In-Network benefits insured by Healthplex Insurance Company 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 15th 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 16th and last day of the month, my coverage will begin on the 1st day of the 2nd month.

#### Credit Card Payment Authorization

By joining this dental plan, I am authorizing Healthplex Insurance Company to bill my credit card for premium due. If I select the monthly recurring payment option, I understand my credit card will be charged automatically each month on a recurring basis for the term of the policy.

#### Termination Policy

I agree to provide Healthplex Insurance Company with written notice at least 14 days prior to termination.

#### Renewal Conditions

This plan will automatically renew at the end of my membership term on an annual basis unless I notify Healthplex Insurance Company of my request to terminate prior to the renewal date.

#### Mail Completed Form To:

Healthplex Insurance Company  
 Attention: Sales  
 P.O. Box 8015  
 Garden City, NY 11530

### NEW YORK STATE REGIONS AND COUNTIES

REGION	COUNTIES
Albany	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Buffalo	Allegany, Cattaraugus, Chautaugua, Erie, Genesee, Niagara, Orleans, Wyoming
Mid-Hudson	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
NYC	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Rochester	Livingston, Monroe, Ontario, Seneca, Wayne, Yates
Syracuse	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins
Utica	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence
Long Island	Nassau, Suffolk

## NOTICE OF NON-DISCRIMINATION

**Healthplex, Inc.**, complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age or sex. **Healthplex, Inc.** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Healthplex, Inc.** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Healthplex, Inc. at 1-888-468-1984. For TTY/TDD services, call 711.

If you believe that **Healthplex, Inc.** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthplex, Inc.** by:

Mail: 333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553-3608  
Phone: 1-800-468-9868 (for TTY/TDD services, call 711)  
Fax: 1-516-228-1734  
In person: Same as Mailing Address (above)  
Email: GA@healthplex.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Mail: U.S. Department of Health and Human Services  
200 Independence Avenue SW., Room 509F, HHH Building  
Washington, DC 20201  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>  
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-468-9868; TTY/TDD 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-468-9868 (TTY: 711).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 1-800-468-9868 (TTY: 711)。	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم هاتف الصم والبكم: (1-800-468-9868). (TTY: 711).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 다 1-800-468-9868 (TTY: 711 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-468-9868 (телетайп: 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-468-9868 (TTY: 711).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-468-9868 (ATS : 711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-468-9868 (TTY: 711).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-468-9868 (TTY: 711).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-468-9868 (TTY: 711).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-468-9868 (TTY: 711).	Tagalog
লক ঙ ক যদি আপনি বা ল কথ্য বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন ক ১-৮০০-৪৬৮-৯৮৬৮ (TTY: ১-৭১১)।	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-468-9868 (TTY: 711).	Albanian
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-468-9868 (TTY: 711).	Vietnamese
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક તમારા માટે ઉપલબ્ધ ફોન કરો 1-800-468-9868 (TTY: 711).	Gujarati
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-468-9868 (TTY: 711).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ (کال کریں 1-800-468-9868) TTY: 711	Urdu
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-468-9868 (TTY 711).	Portuguese
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-468-9868 (TTY: 711).	Thai
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मु त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-468-9868 (TTY: 711) पर कॉल करें।	Hindi
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-468-9868 (TTY: 711).	German