Underwritten by:
International Healthcare Services, Inc.

Administered by:

Please send completed form to:
International Healthcare Services, Inc.
Attention: Enrollments
PO Box 8014 Garden City, NY 11530
P 800-468-0466 F 516-228-9572

INDIVIDUAL ADULT/FAMILY "OFF-EXCHANGE" ENROLLMENT FORM

SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	SSN

Address	City	State	Zip Code

Home Phone	Email Address	Gender	D.O.B.

SPOUSE/DOMESTIC PARTNER[1]/CIVIL UNION PARTNER[2]

Last Name, First Name	SSN	Gender	D.O.B.

DEPENDENTS TO BE COVERED[3]

(If you have more than five (5) dependents, please use an additional enrollment form (FX-0013IHS-OFF-INDIVIDUAL) and attach it to this form)

Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.

[3]Members under 19 will receive pediatric benefits. Dependent children between and including the ages of 19 and 29 will receive adult benefits. Subscriber and dependent spouse/domestic partners/civil union partners shall receive pediatric beneifts until age 19, then adult benefits throughout the term of the policy.

PRIMARY CARE DENTIST (PCD) SELECTION

*Please choose one Primary Care Dentist (PCD) from the **Get Covered NJ Provider Network.** If no selection is made, a PCD will be assigned nearest your home. To view available dentists in the network, visit **healthplex.com** and select "**Our Dentists**" then "**Get Covered NJ Provider Network**".*

Dentist Name	Dentist Site Code

BROKER INFORMATION (IF APPLICABLE)

Broker Name	SSN/Tax ID#

Group Number	Effective Date	Internal Sales Rep

International Healthcare Services, Inc.

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INDIVIDUAL ADULT/FAMILY "OFF-EXCHANGE" ENROLLMENT FORM

COVERAGE

Check One

	Annual Total		Monthly Total
☐ **Individual Adult**	$206.64	☐ **Individual Adult**	$17.22
☐ **2 Member Family**	$413.28	☐ **2 Member Family**	$34.44
☐ **3 Member Family**	$619.92	☐ **3 Member Family**	$51.66
☐ **4+ Member Family**	$826.56	☐ **4+ Member Family**	$68.88

Payment Options:
☐ Check enclosed in the amount of $________________ payable to International Healthcare Services.
or
☐ Credit card - initial amount authorized $________________. Authorize Monthly Recurring Payment? ☐ Yes ☐ No

☐ Visa ☐ MasterCard ☐ 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature*	Date

***All statements made by the subscriber are true and complete to the best of the subscriber's knowledge pursuant to N.J.A.C. 11:4-16.7**

TERMS & CONDITIONS

Benefits

I understand that the In-Network benefits covered by International Healthcare Services, Inc. are only available to me at participating dental offices and that there are no Out-of-Network benefits except for emergency dental care which may, if necessary, be provided by a non-participating provider. A non-participating provider may provide benefits, if authorized, when there is no participating provider available to provide the service. Members and their dependents under 19 will receive pediatric benefits. Dependent children between and including the ages of 19 and 29 will receive adult benefits. Subscriber and dependent spouse/domestic partner/civil union partner shall receive pediatric benefits until age 19, then adult benefits throughtout the term of the policy.

Enrollment Period

If my application and payment is received between the 1st and 25th 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 26th 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 International Healthcare Services, Inc. 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 International Healthcare Services, Inc. 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 International Healthcare Services, Inc. of my request to terminate prior to the renewal date.

Mail Completed Form To:

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