DENCAP dental plans Est. 1984

45 E. Milwaukee Street | Detroit, MI 48202 | Pn: (888) 988-3384 | Fx: (313) 972-4662 | www.dencap.com

DENCAP Dental Plans Enrollment Form: Individual Value Plan (IN-10)

Important information regarding your gift of DENCAP Dental Plans Individual Dental Coverage

- For participating network dental locations, **visit www.dencap.com or call DENCAP for a provider directory at 313-972-1400.**
- Welcome Packet and Member I.D. Card will be mailed within 2 weeks of receipt of completed form.
- Coverage begins the first day of the month following your payment.

Gift Recipient Information

LAST NAME (Print)	FIRST	INITIAL	DATE OF BIRTH MONTH	DAY	YEAR	SEX	SOCIAL SECURITY NUMBER
STREET ADDRESS		Apt#				☐ M ☐ F	– –
CITY	STATE	ZIP	PHONE NUMBER:				
Dental Office Selection *(Choose ONE using a 3 digit number from Provider Directory)* ☐☐☐			E-MAIL:				

LIST ALL DEPENDENTS TO BE COVERED BELOW. INCLUDE LAST NAME IF DIFFERENT FROM SUBSCRIBER		DATE OF BIRTH MONTH	DAY	YEAR	SEX	SOCIAL SECURITY NUMBER
SPOUSE					☐ M ☐ F	– –
DEPENDENT					☐ M ☐ F	– –
DEPENDENT					☐ M ☐ F	– –
DEPENDENT					☐ M ☐ F	– –

Purchaser Contact Information

NAME (PRINT): _____

PHONE NUMBER: _____

ADDRESS: _____ City: _____ State: _____ Zip: _____

Who would you like the Welcome Packet and Member I.D. Card sent to? ☐ **Purchaser** ☐ **Gift Recipient**

Please begin the coverage on the first day of: Month _____ Year _____

Please select ONE of the two payment options below.

☐ **Annual** Payment by **Check or Money Order.** *(Sign below)*
Be sure to enclose check or money order payable to DENCAP for the full ANNUAL Premium.

☐ **Annual** Payment by **Credit/Debit Card.** *(Sign below)* ***Charge Date: To be charged ASAP***

Card Holder/Name on Card: _____

Billing Address *(If different)*: _____ City: _____ State: _____ Zip: _____
The street address and zip code are both required to process payment.

Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____ CVV Code: _____

☐ Visa ☐ MC ☐ Disc ☐ Amex

Annual Rates

Single:	$324.00
2 Persons:	$564.00
Family:	$804.00
Large Family:	$1,044.00

(6 or more dependents)

PLEASE READ TERMS BEFORE SIGNING BELOW

I authorize payment on my credit/debit card (if applicable) or bank draft (if applicable) by signing below. I understand that premiums will be charged to my credit/debit card (if applicable) or bank draft (if applicable) the month prior to coverage effective date.

Fraud Warning: Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or a 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 subjects such person to criminal and civil penalties.

I understand that I am responsible for the co-payments on all services received as specified in the Schedule of Benefits & Co-payments and for full payment of all other non-covered dental services. I am responsible for notifying DENCAP in writing of changes in coverage or payment information. Failure to do so may result in fees, and/or the cancellation of my policy. By signing below I agree to these terms.

Signature: _____ **Date:** _____

Return this form to: DENCAP Dental Plans, Inc. 45 E. Milwaukee Detroit, MI 48202. Or fax to 313-972-4662. Or email to info@dencap.com

Internal Information to be filled out by DENCAP Dental Plans

Confirmed enrollment with: _____ Member #: _____ Group #: _____ Agent: _____

Date: _____ Time: _____ Eff. Mo.: _____ Processed Dt.: _____ General Agent: _____

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