

## DENCAP Dental Plans Enrollment Form: Senior Value Plan (S-5)

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

- For participating network dental locations, visit [www.dencap.com](http://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#				<input type="checkbox"/> M <input type="checkbox"/> F	- -
CITY	STATE	ZIP	PHONE NUMBER:				
<b>Dental Office Selection</b> <i>(Choose ONE using a 3 digit number from Provider Directory)</i>			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		E-MAIL:		
<b>LIST ALL DEPENDENTS TO BE COVERED BELOW. INCLUDE LAST NAME IF DIFFERENT FROM SUBSCRIBER</b>			DATE OF BIRTH MONTH DAY YEAR			SEX	SOCIAL SECURITY NUMBER
SPOUSE						<input type="checkbox"/> M <input type="checkbox"/> F	- -
DEPENDENT						<input type="checkbox"/> M <input type="checkbox"/> F	- -
DEPENDENT						<input type="checkbox"/> M <input type="checkbox"/> F	- -
DEPENDENT						<input type="checkbox"/> M <input type="checkbox"/> 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.

<input type="checkbox"/> <b>Annual</b> Payment by <b>Check or Money Order</b> . <i>(Sign below)</i> <i>Be sure to enclose check or money order payable to DENCAP for the full ANNUAL Premium.</i>	<b>Annual Rates</b>  Single: \$300.00 2 Persons: \$498.00 Family: \$678.00 Large Family: \$918.00 (6 or more dependents)
<input type="checkbox"/> <b>Annual</b> Payment by <b>Credit/Debit Card</b> . <i>(Sign below)</i> <b>Charge Date: To be charged ASAP</b> Card Holder/Name on Card: _____ <input type="checkbox"/> Visa Billing Address (If different): _____ City: _____ State: _____ Zip: _____ <input type="checkbox"/> MC <small>The street address and zip code are both required to process payment.</small> <input type="checkbox"/> Disc Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____ CVV Code: _____ <input type="checkbox"/> Amex	

### 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](mailto: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: \_\_\_\_\_