# 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: Student Dental 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: | $264.00 |
| 2 Persons: | $504.00 |
| Family: | $684.00 |
| Large Family: | $924.00 |

(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: ________