MONTHLY PAYMENT ENROLLMENT FORM
SELECT and SELECT PLUS PLANS

SIMPLE STEPS TO ENROLL

1. Provide Subscriber's Name and Member ID or SSN
2. Choose your payment option
   - If choosing ACH Bank Draft, include a voided check, or a bank specification letter
     (Bank Letter must include account holder's name, account type (checking or savings), account number, and routing number, on bank letterhead)
3. If selecting recurring monthly charge, select payment date
   (DENCAP will withdraw funds on the first business day after the selected date if the date falls on a weekend or a holiday)
4. Funds are to be taken or paid the month prior to coverage effective date.
5. Changes need to be made seven (7) days before the next scheduled payment date to take effect.

IF YOU HAVE QUESTIONS, PLEASE CALL OUR BILLING DEPARTMENT: (313) 972-1400

SUBSCRIBER INFORMATION

Subscriber Name:

Subscriber DENCAP Member Number *or* Social Security Number:

SELECT ONE PAYMENT OPTION

☐Payment Option #1 – ACH BANK DRAFT

Please draft my account every payment period on the day of the month indicated using the information on the **enclosed voided check** or bank specification letter.

☐Payment Option #2 – CREDIT/DEBIT CARD

Please charge my credit/debit card every payment period on the day of the month indicated

Card Holder/Name on Card: _____

Card Holder Billing Address: _____

City: _____ State: _____ Zip: _____

☐Visa ☐MasterCard ☐AmEx ☐Discover Expiration Date: _____

Card Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Payment Charge Date:
(ACH or CC only)
Select ONE Date

☐5th of the month

☐25th of the month

☐Payment Option #3 – PAPER BILL

Please mail me an invoice to the address provided with my enrollment through the Marketplace. Invoices are due on the 25th of each month prior to the month of coverage. Failure to make a payment by the due date may result in cancellation.

AUTHORIZATION AGREEMENT

By filling out this application and signing below I hereby authorize DENCAP Dental Plans, Inc. to initiate automatic withdrawals from the bank account or credit/debit card supplied. I also authorize DENCAP Dental Plans, Inc. to make withdrawals if I make changes in enrollment status of members on my account or in the event that a credit entry is made in error. Further, I agree not to hold DENCAP Dental Plans, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. This agreement will remain in effect until DENCAP Dental Plans Inc. receives a notice of cancellation, or until I submit a new authorization form to DENCAP Dental Plans, Inc. I understand that I am responsible for notifying DENCAP Dental Plans, Inc. in writing of any changes in my bank account or credit/debit card, and that all written notifications of changes must be received by DENCAP Dental Plans, Inc. seven (7) days prior to my next charge date to ensure that the change will go into effect for that charge. I understand that DENCAP Dental Plans, Inc. may charge the funds on the first business day after the above selected charge date if the selected date falls on a weekend or holiday.

Account Holder Signature: _____ Date: _____

Please, return this form to DENCAP Dental Plans, Inc.

Office selection from the DENCAP Provider Directory: ____ ____ ____