



DENCAP Dental Plans Enrollment Form: Sterling Dental (S)

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|-------------------|-------|---------|---------------------------------|-----|------------------------|
| LAST NAME (Print) | FIRST | INITIAL | DATE OF BIRTH MONTH DAY YEAR | SEX | SOCIAL SECURITY NUMBER |
| STREET ADDRESS | | | Apt# | | - - |

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|------|-------|-----|---------------|
| CITY | STATE | ZIP | PHONE NUMBER: |
|------|-------|-----|---------------|

Dental Office Selection (Choose ONE using a 3 digit number from Provider Directory) ➔ *Go to dencap.com for an office locator.*

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|--|--|--|---------------------------------|---|------------------------|
| LIST ALL DEPENDENTS TO BE COVERED BELOW. <input type="checkbox"/> <i>Additional dependents provided separately.</i> | | | 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 | - - |

How did you hear about DENCAP? Web Search Billboard Agent: _____ Other: _____

Please begin my coverage on the first day of: _____ Month _____ Year **I wish to enroll in:** Dental Only OR Dental and Vision

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|--|---|
| <input type="checkbox"/> Annual Payment by Check or Money Order. (Sign below) <i>Be sure to enclose check or money order payable to DENCAP for the full ANNUAL Premium.</i> | Annual Rates |
| <input type="checkbox"/> Annual Payment by Credit/Debit Card. (Sign below) Charge Date: To be charged ASAP | <p>Dental Only: Single: \$300.00 2 Persons: \$498.00 Family: \$678.00</p> <p>Dental and Vision: Single: \$450.00 2 Persons: \$768.00 Family: \$1,146.00</p> |

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|---|---|
| <input type="checkbox"/> 12 Monthly Installments by Credit/Debit Card. Charge Date: <input type="checkbox"/> 5th of every month or <input type="checkbox"/> 25th of every month <i>(After which, plan automatically renews on a monthly basis. Sign below.)</i> | Monthly Rates |
| <input type="checkbox"/> 12 Monthly Installments by ACH (Bank Draft). Charge Date: <input type="checkbox"/> 5th of every month or <input type="checkbox"/> 25th of every month <i>(After which, plan automatically renews on a monthly basis. Sign below.)</i> Enclose voided check or bank letter with account and routing numbers. | <p>Dental Only: Single: \$27.00 2 Persons: \$44.00 Family: \$59.00</p> <p>Dental and Vision: Single: \$40.00 2 Persons: \$67.00 Family: \$98.00</p> |

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 the first charge to activate coverage will take place upon receipt of this enrollment. In some cases due to the effective and payment date selected, the first payment may be for 2 months' coverage _____ (initial), or the selected coverage effective date will be moved forward. I understand that all future premiums will be charged to my credit/debit card (if applicable) or bank draft (if applicable) one month in advance. Monthly Premiums collected are non-refundable.

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 7 days prior to my scheduled payment. Failure to do so may result in fees, and/or the cancellation of my policy. By signing below I agree to these terms.

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.

➔ Account Holder Signature: _____ **Date:** _____

• If submitting electronically, type your name in the account holder signature box. (Your e-mail to DENCAP serves as a binding signature.)

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

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|---|-------|-------|--------|----------------|
| Internal Information to be filled out by DENCAP Dental Plans | | | | f5: V.10.01.20 |
| Confirmed enrollment with: | Date: | Time: | Agent: | General Agent: |