

DENCAP Dental Plans Individual Enrollment Form: Flex (F)



LAST NAME (Print)		FIRST	INITIAL	DATE OF BIRTH MONTH DAY YEAR			SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
STREET ADDRESS			Apt#					- -
CITY		STATE	ZIP	PHONE NUMBER:				
Dental Office Selection (Enter 3 digit number from Provider Directory)				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Go to dencap.com for an online directory.		
E-MAIL:								

LIST ALL DEPENDENTS TO BE COVERED BELOW.		<input type="checkbox"/> Additional dependents provided separately.		DATE OF BIRTH MONTH DAY YEAR			SEX <input type="checkbox"/> M <input type="checkbox"/> F	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 _____

Please select ONE of the four payment options below.

<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 Single: \$203.16 2 Persons: \$406.32 Family: \$609.48
<input type="checkbox"/> Annual Payment by Credit/Debit Card. (Sign below) Charge Date: To be charged ASAP Card Holder/Name on Card: _____ Billing Address: _____ City: _____ State: _____ Zip: _____ <i>The street address and zip code are both required to process payment.</i> Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____ <div><input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Disc <input type="checkbox"/> Amex</div>	
<input type="checkbox"/> 12 Monthly Installments by Credit/Debit Card. Billing Withdrawal Date is the 25th of each month (After which, plan automatically renews on a monthly basis. Sign below.) Card Holder/Name on Card: _____ Billing Address: _____ City: _____ State: _____ Zip: _____ <i>The street address and zip code are both required to process payment.</i> Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____ <div><input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Disc <input type="checkbox"/> Amex</div>	Monthly Rates Single: \$16.93 2 Persons: \$33.86 Family: \$50.79
<input type="checkbox"/> 12 Monthly Installments by ACH (Bank Draft). Billing Withdrawal Date is the 25th of each month (After which, plan automatically renews on a monthly basis. Sign below.) Enclose voided check or bank letter with account and routing numbers.	

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, 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 844-919-1601. Or email to enrollments@dencap.com

Internal Information to be filled out by DENCAP Dental Plans

Confirmed enrollment with: _____ Date: _____ Time: _____ Agent NPN: _____ General Agent NPN: _____