

**Monthly Payment Enrollment Form - Marketplace 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. Funds are to be taken or paid the month prior to coverage effective date.
4. Changes need to be made in writing seven (7) days before the next scheduled payment date to take effect.

**If you have any questions, please call our billing department: (313) 972-1400**

**Subscriber Information**

Subscriber Name: \_\_\_\_\_

Subscriber DENCAP Member Number or Social Security Number: \_\_\_\_\_

Dental Office Selection ➡     *(Choose ONE using a 4 digit dental office ID from the online DENCAP Provider Directory at dencap.com)*

**Select ONE Payment Option**

**Payment Option #1 - ACH Bank Draft** Please draft my account every payment period on the 25th of the month, using the information on the **enclosed voided check** or bank specification letter.

OR

**Payment Option #2 - Credit/Debit Card** Please charge my credit/debit card every payment period on the 25th of the month.

Card Holder/Name on Card: \_\_\_\_\_  Visa |  MC |  Disc |  Amex

Card Holder Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
*The street address and zip code are both required to process payment.*

Credit/ Debit Card #:                 Credit/Debit Expiration Date: \_\_\_\_\_

OR

**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 20th of each month prior to the month of coverage. Failure to make a payment by the due date may result in cancellation.

**Authorization Agreement**

*Please Read Terms BEFORE Signing Below*

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 written notice of cancellation from me or my financial institution, 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 may charge the funds on the first business day after the 25th when the charge date falls on a banking holiday.

Account Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_