45 E. Milwaukee Street | Detroit, Michigan 48202
t: (313) 972-1400 | f: (844) 919-1601 | dencap.com

DENCAP Dental Plans Enrollment Form: UFCW Advantage Dental (A)

Clear Data

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 *(Enter 4 digit number from Provider Directory)* ☐☐☐☐ *Go to dencap.com for an online directory.*			E-MAIL:		

LIST ALL DEPENDENTS TO BE COVERED BELOW. ☐ *Additional dependents provided separately.*		DATE OF BIRTH MONTH DAY YEAR	SEX	SOCIAL SECURITY NUMBER
SPOUSE			☐ M ☐ F	– –
DEPENDENT			☐ M ☐ F	– –
DEPENDENT			☐ M ☐ 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.

☐ **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: _____ City: _____ State: _____ Zip: _____
The street address and zip code are both required to process payment.

Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____

☐ Visa ☐ MC ☐ Disc ☐ Amex

Annual Rates

Single: $270.00
2 Persons: $456.00
Family: $696.00

☐ **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: _____
The street address and zip code are both required to process payment.

Credit/ Debit Card #: _____ Credit/Debit Expiration Date: _____

☐ Visa ☐ MC ☐ Disc ☐ Amex

☐ **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.***

Monthly Rates

Single: $23.50
2 Persons: $40.00
Family: $60.00

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.)

Email This Form

f5-V12.07.23

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: _____