Clear Data

dencap DENTAL PLANS

45 E. Milwaukee St. | Detroit, MI 48202 | t: (844) 433-6227 | f: (844) 919-1601 | dencap.com

DENCAP Dental Plans Group Enrollment Form - Choice 1500 (CH15)

Employer (Applicant) Information *(Must submit member enrollment form for each person on the plan)*

Legal Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Contact: _____ Title: _____

Effective Date Requested: _____

(NOTE: The requested date must be the first day of a calendar month)

Premium Calculation

	☐ DENTAL PLAN
Employee Only # _____ ➡	x $36.75 = $ 0.00
Employee + 1 Person # _____ ➡	x $73.49 = $ 0.00
Employee + 2 or More Persons # _____ ➡	x $110.24 = $ 0.00
	Total = $ 0.00

Payment Options (Select Only One)

NOTE:

For ACH and credit card options below, funds to be taken the month prior to coverage effective date. If this is not possible, the first withdrawal will be for 2 months of coverage.

☐ Credit Card*

☐ Visa | ☐ MC | ☐ Disc | ☐ Amex

Card Holder/Name on Card: _____

Billing Address : _____

City: _____ State: _____ Zip: _____

Credit/ Debit Card #: _____

Credit/Debit Expiration Date: _____

Billing Withdrawal Date is the 25th of each month

☐ ACH Bank Draft*

NOTE: Please attach a voided company check or bank letter specification sheet that includes the account and routing #'s and account holder.

Billing Withdrawal Date is the 25th of each month.

☐ Company Check

NOTE: Please include check with application. ***(Payment is due by the 25th of the month prior to coverage)***

Billing Frequency (Select ONE option) ☐ Monthly | ☐ Quarterly | ☐ Annual | ☐ Semiannual

*I hereby authorize DENCAP Dental Plans, Inc. to initiate automatic withdrawals from my account at the financial institution indicated above. I also authorize DENCAP Dental Plans, Inc. to make withdrawals from this account in the event that changes in enrollment affect premiums due. 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 by 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 hereby enroll in the Choice 1500 Group Dental Plan. I understand that I must maintain the minimum number of five (5) employees enrolled in this dental plan or a minimum of ten (10) total employees combined in two dental plans in order to maintain this same coverage. Any changes must be made in writing to DENCAP Dental Plans.

Effective Dates of Coverage: Dental coverage will become effective on the first day of the month. Enrollment materials, company check, company credit card or ACH withdrawal information for the first month's coverage must be received at DENCAP by the **20th** of the month prior to the requested effective date.

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.

NOTE: Please include agent information (if applicable) before submitting to DENCAP Dental Plans.

Signature of Employer/Applicant: _____ Title: _____ Date: _____

Signature of Agent: _____ Agent NPN: _____

Print Name of Agent: _____ General Agent NPN: _____

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

Email This Form

fs: PY25- V.05.05.25

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