

**DENCAP Dental Plans Group Enrollment Form - Prestige 1800 (PS18)**

**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 (Select Only One Plan)**

	<input type="checkbox"/> <b>DENTAL ONLY</b>	<input type="checkbox"/> <b>DENTAL PLUS COSMETIC</b>
Employee Only # _____ →	x \$41.28 = \$ _____	x \$43.61 = \$ _____
Employee + 1 Person # _____ →	x \$81.08 = \$ _____	x \$91.52 = \$ _____
Employee + 2 or More Persons # _____ →	x \$151.78 = \$ _____	x \$169.97 = \$ _____
	<b>Total = \$ _____</b>	<b>Total = \$ _____</b>

**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 Prestige 1800 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.)**