

New York CapDent Individual Dental Plan Enrollment Form

Member Information						
Group Number I 'E'F'K' 4			Effective Date			
Last Name		First Name		M.I.	SSN/ID#	
Address			City		State Zip Code	
Home Phone		Email Address		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.	
Marital Status						
<input type="checkbox"/> Single <input type="checkbox"/> Domestic Partners <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Widow						
Dependents To Be Covered (Spouse, Domestic Partner & Unmarried Dependent Children under 19 years of Age / 25 if Full-Time Student. Attach student documentation to Enrollment Form.)						
Last Name, First Name		M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name		M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Dental Selection - Select from the CapDent & CapDent Plus Provider Directory						
<u>Dentist Name</u>		<u>Dentist Site Code</u>		I understand that CapDent In-Network Benefits are only available at participating CapDent dental offices.		
Coverage Selected - Annual Billing						
<input type="checkbox"/> Single - \$177.00		<input type="checkbox"/> Two Party - \$300.00		<input type="checkbox"/> Family - \$408.00		
Payment Options						
<input type="checkbox"/> Check enclosed in the amount of \$ _____ payable to Dentcare Delivery Systems, Inc.						
<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard (check one) Annual Authorization in the amount of \$ _____						
Name on Card: _____						
Card Number: _____ Exp. Date: _____						
I agree to maintain enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a 12-month period. When billed annually, a Cancellation fee of \$25.00 will be applied to your prorated refund if policy is terminated prior to your expiration date. To enroll on the 1st day of a given month, Enrollment Form and payment must be received by the 15th of the prior month.						
Signature					Date	
Broker Information						
Broker Name				SSN/Tax ID #		
Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.						

"PLEASE PRINT OR TYPE ALL INFORMATION"

Mail to: Dentcare Delivery Systems, Inc.

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