

**NEW YORK CAPDENT ♦ CAPDENT PLUS DENTAL PLANS -- MONTHLY RATE AND PAYMENT FO**

F-2119 (Rev 2001)

<u>Annual Billing</u>			<u>Group Premium Billing available on Monthly Basis</u>			
Please	<b>CapDent (Non-Group)</b>		<b>CapDent (Group)</b>		<b>CapDent Plus (Group)</b>	
<i>select</i>	<input type="checkbox"/> Single	\$159.00	<input type="checkbox"/> Single	\$13.25	<input type="checkbox"/> Single	\$22.00
<b>one</b>	<input type="checkbox"/> Two-Party	\$264.00	<input type="checkbox"/> Two-Party	\$22.00	<input type="checkbox"/> Two-Party	\$38.00
<i>plan</i>	<input type="checkbox"/> Family	\$350.00	<input type="checkbox"/> Family	\$30.00	<input type="checkbox"/> Family	\$55.00

Check enclosed in the amount of \$ \_\_\_\_\_ payable to **Dentcare Delivery Systems, Inc.**

- VISA or MASTERCARD (circle one)
- GROUP** Monthly authorization until canceled by me in writing in the amount of \$ \_\_\_\_\_
  - Capdent **INDIVIDUAL** plan annual authorization in the amount of \$ \_\_\_\_\_

Name \_\_\_\_\_ Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**MAIL TO: DENTCARE DELIVERY SYSTEMS, INC., 60 CHARLES LINDBERGH BLVD, UNIONDALE, NY 11553**

To enroll on the 1<sup>st</sup> day of a given month, enrollment materials **must be received by the 15<sup>th</sup>** day of the preceding month. Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

AGENT/BROKER NAME \_\_\_\_\_ TAX ID # \_\_\_\_\_  
8/03

**NEW YORK CAPDENT ♦ CAPDENT PLUS DENTAL PLANS -- ENROLLMENT CARD**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Home Telephone # \_\_\_\_\_ Office Telephone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_  Single  Married  Divorced/Widow

**DEPENDENTS** **MARITAL STATUS** Check Relationship

Last Name	First	M.I.	M/F	Spse
Son	Dtr	Birth Date		
				/ /
				/ /
				/ /
				/ /
				/ /

Group Name \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

**Plan Selection**

\* CapDent -- (Select Provider)

CapDent Plus -- If you would like to use the services of a participating dentist, please enter the **Dentist's Name and Code Number** from our list of providers:

**Capdent Dentist Name:** \_\_\_\_\_

**Capdent Dentist Code:** \_\_\_\_\_

\*I understand that Capdent In-Network Benefits are only available at participating Capdent dental offices.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

I agree to maintain my enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a twelve month period.