

DENTAL PLAN ENROLLMENT FORM

FOR DENTAL PLANS BY DENTCARE DELIVERY SYSTEMS, INC., INTERNATIONAL HEALTHCARE SERVICES, INC., HEALTHPLEX INS. COMPANY, OR HEALTHPLEX, INC.

Last Name _____ First Name _____ M.I. _____ Social Security # _____
 Address _____ Date of Birth _____
 City, State, Zip _____ Home Telephone _____
 Employer Name / Group (if any) _____ Group # _____ Office Telephone _____ Date of Hire _____

GENDER: M F COVERAGE SELECTED: SINGLE HUSBAND & WIFE / PARENT & CHILD FAMILY / PARENT & CHILDREN
 OTHER DENTAL COVERAGE: NO YES NAME OF OTHER PLAN (if any): _____

PLAN SELECTION: CAPDENT- INDIVIDUAL (may be subject to early cancellation fee)
 STANDARD GROUP PLAN CAPDENT-GROUP CAPDENT PLUS-GROUP CAPDENT PLUS ULTRA-GROUP
 _____ Managed Care Option COMPREHENSIVE VOLUNTARY _____ LOW _____ MEDIUM _____ HIGH _____ HIGH ENHANCED (check one)
 _____ Reimbursement Option PREFERRED PLAN - GROUP OMNI PLAN - GROUP OTHER (SPECIFY) _____

DENTIST SELECTION (FOR MANAGED CARE OPTION): _____ **DENTIST SITE CODE:** _____

DEPENDENTS TO BE COVERED (Spouse & unmarried dependent children)

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

Agent Name (if applicable): _____
 Agent Tax ID #: _____

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.

SIGNATURE _____ **DATE** _____ **EFFECTIVE DATE** _____