

UT/TX Individual Enrollment Form

Use the Individual Enrollment Form to collect first time subscriber and dependent information. For existing member changes, please use the Change Form.

Choose Your Plan Options (These Plans are Available in UT/TX Only)

<input type="checkbox"/> Coinsurance	<input type="checkbox"/> Copay	<input type="checkbox"/> Gold Network
<input type="checkbox"/> Coinsurance Plus		<input type="checkbox"/> Platinum Network
<input checked="" type="checkbox"/> EyeMed Discount Vision Program Included		

Must Be Completed in Full - PLEASE PRINT

SSN		Date of Birth (MM/DD/YYYY)	
First Name	M.I.	Last Name	
Address			
City	State	Zip Code	
Phone #	<input type="checkbox"/> OK to Text	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Email Address			
Requested Effective Date (MM/DD/YYYY)			
Name of Employer		Employer Phone Number	
Agent Name			
Agent Number		Agent Phone Number	

Individuals Covered

Spouse Name (Last, First, M.I.)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
SSN	Relationship	Date of Birth
Dependent Name (Last, First, M.I.)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
SSN	Relationship	Date of Birth

For additional dependents, please attach separate sheet.

Covered by Other Dental Insurance? Yes No

Name of Person Insured	
SSN	Name of Other Insurance Company

Payment Options

Billing Period:	<input type="checkbox"/> Monthly (Withdrawn on the 15th or next 2 business days)
	<input type="checkbox"/> Annual (Check or Credit Card)
	Is this insurance intended to replace any other accident and health insurance presently in force? <input type="checkbox"/> Yes <input type="checkbox"/> No

Checking or Savings

<input type="checkbox"/> Checking Account (Include Voided Check)	<input type="checkbox"/> Savings Account (Include Deposit Slip)
Financial Institution:	
Routing Number:	
Account Number:	

Credit Card Payment

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD
Account Number: □□□□□□□□□□□□□□□□	Exp. Date: □□/□□
Account Holder Name:	
Account Holder Signature: _____	
Date: _____	

Authorization of Coverage

I wish to enroll in the plan I have selected. I authorize and agree to account deduction of the required premium.

This authorization will appear on my statement as Dental Select, and remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution, per their cancellation guidelines, before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. Please direct billing inquiries to Dental Select, 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, UT 84070. I have read and understand the statements above pertaining to the billing option. Your cancellation will be effective the first day of the month following the month your written request is received.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In the event there are insufficient funds when a draft is charged to my account, I agree to pay \$25 NSF Fee. The 3rd returned check in any 12 month period will result in the immediate cancellation of my policy. Dental Select reserves the right to deny me the ability to be reinstated on any personal Dental Select plan for two years based on NSF or credit card declinations.

Signature: _____	Date: _____
------------------	-------------

The policy provides limited benefits. Review your policy carefully.

Please fill out and return this Enrollment Form with your payment to:

Enrollment Department
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy UT, 84070

Phone: 800-999-9789
Fax: 888-998-8711
dentalselect.com



All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by Ameritas Life Insurance Corp.; both affiliates of Ameritas Mutual Holding Company. 5900 O Street / P.O. Box 81889 / Lincoln, NE 68501-1889