DentalSelect

Dental Plan Enrollment Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8711 **DentalSelect.com**

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

Last Name	**First Name**	
Street Address		
City	**State**	**Zip Code**
Home Phone	**Date of Birth** (MM/DD/YYYY)	
SSN	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female
Employer's Name & Phone Number		
Agent Name		
Agent Number	**Requested Effective Date** (MM/DD/YY)	
Where did you hear about us?		

List all dependents to be covered

Spouse Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**Date of Birth** - (MM/DD/YYYY)
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**Date of Birth** - (MM/DD/YYYY)
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**Date of Birth** - (MM/DD/YYYY)
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**Date of Birth** - (MM/DD/YYYY)
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**Date of Birth** - (MM/DD/YYYY)
Dependent Name - (Last, First, MI)	**Gender** ☐ Male ☐ Female	**Date of Birth** - (MM/DD/YYYY)

For additional dependents attach an additional sheet

Covered by other DENTAL Insurance? ☐ Yes ☐ No	Name of Person Insured
If Yes, Name of other Dental Insurance Company	Social Security Number

Choose Your Plan Type *(Choose only one - Plan choices may vary per state.)*

☐ **Individual Plan** ☐ **Individual Senior Plan**

☐ **Individual Association Plan**
Association Name (Required):

Choose Your Plan Option *(Choose only one - Plan choices may vary per state.)*

Discount Plan *(Non-insured plan)*

☐ **Silver Network**

Co-Pay Plans

☐ **Gold Network** ☐ **Platinum Network**

Co-Insurance Plans

Option 1	Option 2
☐ Gold Network	☐ Gold Network
☐ Platinum Network	☐ Platinum Network

EyeMed Discount Vision Plan included with all dental plans

Payment Options *(Choose either Checking/Savings or Credit Card Payment)*

Billing Period: ☐ Monthly *(Withdrawn on the 16th or next 2 business days)* ☐ Annual *(Check or Credit Card)*

Checking or Savings *(Include a $15.00 enrollment fee with your payment)*

☐ Checking Account *(Include Voided Check)* ☐ Savings Account *(Include Deposit Slip)*

Financial Institution:

Routing Number:

Account Number:

Credit Card Payment *(Include your check for the $15.00 enrollment fee)*

☐ **VISA** ☐ **MASTERCARD**

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Account Holder Name:

Account Holder Signature: Date:

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

Signature: Date:

This authorization will 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 at least three business days 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, 5373 S. Green Street., 4th Floor, Salt Lake City, UT 84123. 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.

ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. Gold and Platinum plans of insurance are underwritten by ACE American Insurance Company.
ace usa

Please fill out and return this enrollment form with your payment to:

DENTAL SELECT – CORPORATE OFFICE 5373 S. GREEN STREET, 4TH FLOOR, SALT LAKE CITY, UTAH 84123 Toll Free (800) 999-9789 Toll Free Fax (888) 998-8711

www.dentalselect.com