

DENTAL COVERAGE ENROLLMENT FORM



Please note: You must be a member of the Money Savers of America Association to obtain this dental coverage.

Please Print

Name - Last	First	MI	Home Phone ()
Home Address - Number & Street	City	State	Zip Code
Sex (circle one) M or F	Birthdate / /	Social Security Number	

Check the type of contract and list all members:

Single Single and spouse Single and child(ren) Family

MEMBERS (List all members below. If additional space is required, please attach a list.)

Last	<u>NAME</u>			<u>DATE OF BIRTH</u>			<u>SEX</u>	
	First	MI		MO	DAY	YR	M	F
<i>Spouse</i>								
<i>Dependent</i>								
<i>Dependent</i>								
<i>Dependent</i>								
<i>Dependent</i>								

By signing this enrollment form, you agree to the terms and conditions listed on the back. Please read carefully before signing. Make a copy of both sides for your records.

SHADED AREA FOR DELTA DENTAL OFFICE USE ONLY

Beginning Effective Date	Agent #
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Delta Dental reserves the right to assign effective dates.

Agent to complete before sending to Delta Dental

Agent Name (printed)	Social Sec. #/Tax ID # and/or Agent #
Agent Address	Phone Number
Agent Signature	Date

Please note: You must be a member of the Money Savers of America Association to obtain this dental coverage.

PAYMENT METHOD

Acceptable premium payment methods are check (annual), credit card (annual) or bank draft (monthly). Select one of the payment methods listed below and enclose your payment along with this application in the enclosed self addressed envelope. Incomplete enrollment forms or those designating no method of payment will be returned unprocessed. All applications received by the 10th of the month will be effective the 1st of the following month. Any applications received after the 10th of the month will not be effective until the 1st of the second following month, or up to 50 days later. Refer to the enclosed rate sheet to determine the amount of your premium payment.

CHECK (Annual only) **Please make check payable to Delta Dental Plan of Kentucky.**

VISA **MASTERCARD** (Annual only)

Card Number _____ Expiration Date _____

Signature _____ Date _____

BANK DRAFT (Monthly)

A) A **voided check** must accompany this application in order to accurately establish your withdrawal. **We cannot accept a deposit slip.** The draft process will originate from our office on the 17th of each month and should reach your account for processing within three working days.

B) A \$50.00 refundable **Deposit** must accompany this enrollment form. The \$50.00 deposit will be retained by Dental Choice during the term of this contract and subsequent contract renewal periods. The deposit will be refunded only if this contract is terminated on the initial contract renewal date or any subsequent contract renewal dates. The deposit will not be refunded if this contract is terminated prior to any contract renewal date. **Please make check payable to Delta Dental Plan of Kentucky.**

C) Monthly bank drafts will remain in full force and effective until Delta Dental Plan of Kentucky and your bank (depository) have received written notification from you of termination and in such time and in such manner as to afford the depository a reasonable time to act on it. If termination occurs before your contract has been fulfilled, your deposit will be forfeited.

Signature _____ Date _____

IMPORTANT: If you do not want the contract for any reason, you may return it to us within 10 days after you receive it. Upon return, the contract will be deemed void, and any money you have paid will be refunded. In accepting this contract, you agree to participation in this plan for the full 12-month benefit period. Termination of this contract prior to the completion of your 12-month benefit period automatically terminates all your coverage as of your effective date, whether or not a specific condition was incurred prior to the termination date. You will be responsible to refund payment to Dental Choice for any services received by you or your dependents during that time period and Dental Choice will retain all premiums paid during that time period to cover administrative expenses.

I acknowledge that I have read the provisions of this enrollment form and I expressly accept such provisions as a condition of coverage. I understand that my membership is for a 12 month period and on my anniversary date I can renew or cancel or change the type of contract. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Delta Dental Plan of Kentucky in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this form, the dental contract, and the identification card will constitute the contract.

Applicant Signature _____ Date _____

MEMBER REGISTRATION



\$15 non-refundable Annual Dues covers member and family for a full 12 months.

Please Print

Name - Last	First	MI	Home Phone ()
Home Address - Number & Street	City	State	Zip Code
Sex (circle one) M or F	Birthdate / /	Social Security Number	

Agent Information (if applicable)

Agent Name (printed)	Social Sec. #/Tax ID # and/or Agent #
Agent Address	Phone Number
Agent Signature	Date

PAYMENT OPTIONS

CHECK Please make check payable to Money Savers of America and return in enclosed envelope to:
Money Savers of America c/o PlanChoice
3010 Taylor Springs Drive
Louisville, KY 40220

VISA **MASTERCARD**

Card Number _____ Expiration Date _____

Signature _____ Date _____

ADDITIONAL BENEFIT OPTIONS

Yes, I would like to participate in the Delta Dental Preferred Option for Individual and Families dental coverage (information enclosed).

Please complete the dental enrollment form and return with this MSA Registration form in the enclosed envelope.

I would like to receive additional information on the following Association plans.

Please check your selections:

- | | |
|----------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Group Dental | <input type="checkbox"/> Final Expense |
| <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Health Insurance |
| <input type="checkbox"/> Discounted Long Term Care | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> Medical Supplements | <input type="checkbox"/> Other: _____ |