SmartSmile℠ Enrollment Form

First Name | Last | M.I. | Social Security Number

Address | City | State | Zip Code

Home Phone # | Work Phone # | E-mail Address | Birthdate

Dentist # - Found to the left of the dentist's name on the enclosed directory

Requested Effective Date - Enroll by the 20th of one month to be eligible for the first of the following month.

Sex
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married

Why did you decide to enroll?
☐ Need immediate care
☐ Cost effectiveness
☐ Self-employed
☐ No employer benefits
☐ Retired
☐ Other_____

Where did you hear of us?
☐ Yellow Pages
☐ Insurance Commissioner
☐ Friend or relative
☐ Broker or agent
☐ Dentist
☐ Other_____

For Office Use Only

Effective Date	Cycle	Group #
I	A M SCHD9I	IDP

Northwest Indemnity Services / Stewart Poths — Agent Name

W1532 — Agent#

Dependants to be covered*:

Last Name (if different)	First Name	M.I.	Sex M F	Child or Spouse	Birthdate
1					
2					
3					
4					
5					
6					

I authorize my dentist to release any information regarding my patient history to Dental Health Services, consulting professional or other entity designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am over 18 years of age.

* Dependants include your spouse, domestic partner, and /or unmarried children who are under 19 years of age. Children over 19 years of age are eligible only if: 1) The child is unmarried, under 23 years of age and a full time student solely dependent upon subscriber for support; or 2) While the child is and continues to be both (1) incapable of sustaining employment by reason of development disability or physical handicap, and (2) is chiefly dependent upon the subscriber for support and maintenance.

Please select ONE of the five following payment options:

☐ 1. Check - Annual Payment
☐ 2. Money Order - Annual Payment
☐ 3. Credit Card - Annual Payment
☐ 4. Credit Card - Automatic Monthly Payments
☐Visa™ ☐MasterCard™ ☐Discover Card

Credit Card Number | Expiration Date

$ Amount (Annual or Monthly)

Signature | Date

☐ 5. Automatic Checking Withdrawal - Monthly Payments

A security deposit in the amount of 1-month premium will be held by Dental Health Services to be used in the event that automatic withdrawal is unavailable due to insufficient funds. I have included a check for the initial 2-month premium.

Automatic checking withdrawal or monthly credit charges will begin the month following your eligibility date and will continue on the fifth of each month you are enrolled on the plan. By selecting payment option #4 or #5, I hereby authorize Dental Health Services to withdraw the applicable monthly payment (premium) from my account. The authorization is to remain in full force and effect for a minimum of a one (1) year period and will renew automatically unless written notice is received 60 days prior to expiration of the annual term.

Annual Premium

Subscriber	$201.60
Subscriber + 1 dependant	$330.00
Subscriber + 2 dependants	$430.80
Subscriber + 3 or more dependants	$552.00

Monthly Premium
(Automatic checking withdrawal requires an initial 2-month payment).

Subscriber	$16.80
Subscriber + 1 dependant	$27.50
Subscriber + 2 dependants	$35.90
Subscriber + 3 or more dependants	$46.00

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