

DENTAL SOLUTIONS PLUS

PLAN 2000 APPLICATION

12946 Dairy Ashford Ste. 360
 Sugar Land, TX 77478
 (901) 322-6065 FAX (901) 322-6042

Applicant _____
Last Name First Middle Ini

Social Security Number _____

Address _____

Requested Effective Date _____
(ALL MEMBERSHIPS START ON THE 1ST OF THE MONTH)

City _____ State _____ Zip _____

Telephone: Home _____ Work _____

Birthdate (mo/day/year) ____ / ____ / ____ Sex M F

Dentist _____ Number _____
***** You MUST choose a dentist to be enrolled*****

Please Check (One) Method of Payment Below:

Bank Draft - On the 1st day of each month
(INCLUDE 1ST MONTH PAYMENT WITH ENROLLMENT FEE and voided check)

ENCLOSED is my first Semi-Annual or Annual payment including Enrollment Fee, thereafter bill me:

Semi-Annually 6 months
 Annually - 12 months

	Last Name (If Different)	First Name	Middle Initial	Sex M/F	Birthdate (mo/day/year)
Spouse					
Child					
Child					
Child					
Child					

Coverage	Monthly Premium	Months	Sub Total	Enrollment Fee	Total Payment
Individual	\$11.00	X _____ =	_____ +	\$15.00 =	_____
Individual + 1	\$19.00	X _____ =	_____ +	\$15.00 =	_____
Family	\$24.00	X _____ =	_____ +	\$15.00 =	_____

I hereby apply for coverage under Plan 2000. I enclose my first payment of Premium and Enrollment Fees.
 I understand that this Policy is personal and portable.

 Signature

 Date

 Agent Name

 Number