



Premier 120-01 Plans Enrollment Form

Please complete this form by printing in ink or typing.

Name _____

Social Security Number _____ - _____ - _____

Address _____

Employer _____

City _____ State _____ Zip Code _____

Marital Status Married Single _____ # of Dependents _____

Home Phone (_____) _____

Work Phone (_____) _____

Please indicate your primary language here: _____

Disability which affects communication : _____

I wish to cover the following eligible family members:

Name (Last, First, Initial)	Sex	Date of Birth
Enrollee _____	<input type="radio"/> M <input type="radio"/> F	___/___/___
Spouse _____	<input type="radio"/> M <input type="radio"/> F	___/___/___
Child _____	<input type="radio"/> M <input type="radio"/> F	___/___/___
Child _____	<input type="radio"/> M <input type="radio"/> F	___/___/___
Child _____	<input type="radio"/> M <input type="radio"/> F	___/___/___
Child _____	<input type="radio"/> M <input type="radio"/> F	___/___/___

IMPORTANT

Select A Dentist from the OraQuest Provider List

Dentist Name

OraQuest Provider ID#

Determine applicable monthly rate:

- Subscriber Only\$7.95 per month*
- Subscriber plus 1 dependent\$14.00 per month*
- Subscriber plus family\$19.00 per month*

1. I hereby apply for membership in the OraQuest Premier 120-01 Plan for myself and any eligible dependents listed.
2. I represent that the information provided is true and correct to the best of my knowledge.

Please Sign & Date This Form Here

Did You Remember To Select A Dentist In The Space Above? *

Signature: _____ Date: _____

Pay Monthly By Bank Draft

Pay Annually By Check or Credit Card

To pay your premiums monthly by automatic bank draft from your checking account please enclose a check with this application for the first month's premium plus the \$15 enrollment fee. Also enclose a blank, voided check from the account we are to draft. Future premiums will be drafted from your account around the 7th day of each month.

To pay your premiums for a year in advance please enclose credit card information or a check with this application for twelve months of premium plus the \$15 enrollment fee. **If premium was paid by credit card, future annual payments will be automatically charged to your credit card upon renewal.** Approximately 30 days prior to your renewal date you will receive a notice.

Monthly Payment Premium Calculation:

Monthly Billing - **BANK DRAFT OPTION ONLY** *\$ _____
 One Time Enrollment Fee _____ \$15.00
 Total amount due to enroll: \$ _____

Annual Payment Premium Calculation:

Annual Billing (\$ _____ * x 12) \$ _____
 One Time Enrollment Fee _____ \$15.00
 Total amount due to enroll: \$ _____

For Bank Draft Payment Only

Sign this authorization and attach a voided check plus a check for the first month's premium plus the enrollment fee.

Bank Draft Authorization: I hereby request and authorize you to pay checks drawn on my account by OraQuest provided there are sufficient funds in said account to pay the same upon presentation.

Signature: _____

For Credit Card Payment Only

I authorize OraQuest Dental Plans to charge my credit card for payment of this dental plan premium.

Credit Card Number _____

Expiration Date _____ Signature _____

MasterCard, VISA, Discover, and American Express accepted.

For Office Use Only

Agent: _____

OraQuest Dental Plans is a dental HMO licensed by the Texas Department of Insurance.

Make checks payable to OraQuest Dental Plans

M-120-01 (03/03)

and mail this form to:

OraQuest Dental Plans
 12946 DAIRY ASHFORD, SUITE 360
 SUGAR LAND, TX 77478
 Phone: (281) 313-7170 or 1-800-660-6064
 Fax: (281) 313-7155