Premier 120-01 Plans Enrollment Form

Please complete this form by printing in ink or typing.

Name ____

Address ____

City _________________ State ______ Zip Code ___________

Home Phone (_______) _____________________________

Please indicate your primary language here:_______________

Social Security Number _________ - _________ - ___________

Employer ____

Marital Status o Married o Single ______ # of Dependents

Work Phone (_______) _______________________________

Disability which affects communication: ____________________

I wish to cover the following eligible family members:

	Name (Last, First, Initial)	Sex	Date of Birth
Enrollee	________________________________	o M o F	____/____/____
Spouse	________________________________	o M o F	____/____/____
Child	________________________________	o M o F	____/____/____
Child	________________________________	o M o F	____/____/____
Child	________________________________	o M o F	____/____/____
Child	________________________________	o M o F	____/____/____

IMPORTANT

Select A Dentist from the OraQuest Provider List

____
Dentist Name

____
OraQuest Provider ID#

Determine applicable monthly rate:

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

Please Sign & Date This Form Here
Did You Remember To Select A Dentist In The Space Above? *

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.

Signature: _________________________ Date: ________

Pay Monthly By Bank Draft

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.

Monthly Payment Premium Calculation:

o Monthly Billing - **BANK DRAFT OPTION ONLY** *$________

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: ____

Pay Annually By Check or Credit Card

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.

Annual Payment Premium Calculation:

o Annual Billing ($________* x 12) $________

One Time Enrollment Fee ____$15.00

Total amount due to enroll: $________

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 mail this form to:

OraQuest Dental Plans
101 Parklane Blvd., Suite 301
SUGAR LAND, TX 77478
Phone: (281) 313-7170 or 1-800-660-6064
Fax: (281) 313-7155