

004D07253

DentiCare, Inc. Application Form

Select Individual Prepaid Dental Plan

Your Social Security Number	Last Name	First Name	Middle Initial	Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Your Date of Birth	Address				
Home Phone ()	City	State	Zip		

IMPORTANT
Write the Dental Facility ID# of the dentist(s) you choose from the directory in this space(s) below.

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List Dependents to be Enrolled	First Name	Middle Initial	Last Name (if different)	Relationship	Date of Birth	Sex
Spouse					/ /	M <input type="checkbox"/> F <input type="checkbox"/>
Child					/ /	M <input type="checkbox"/> F <input type="checkbox"/>
Child*					/ /	M <input type="checkbox"/> F <input type="checkbox"/>

Attach a separate sheet of paper for additional children.

Prepayment Fee Amount \$	Select Payment Choice <input type="checkbox"/> Annual Payment or Charge my annual prepayment fee OR <input type="checkbox"/> Automatic Monthly Bank Draft <small>Complete the Authorization Agreement on the reverse side of this form.</small>	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover	Exp. Date	/												
+ Enrollment Fee \$ 35.00						Mo.			Yr.										
Total Enclosed \$		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																	

By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of plans will be provided in the Individual Prepaid Dental Plan Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Fortis Benefits my dental records, photocopies or information regarding such procedures to the extent permitted by law.

Rep's Signature Keith Nabb Date _____ Subscriber's Signature _____ Date _____

KC4173BGA-E 11.60 18.63 28.37 127.20 211.56 328.44 Make checks payable to Fortis Benefits. Please retain a copy of this application for your records. This is an important document that will become part of your contract.

Authorization Agreement For Automatic Monthly Bank Draft

Name(s)	Social Security Number	Checking <input type="checkbox"/>	Savings <input type="checkbox"/>
I (we) hereby authorize Fortis Benefits to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.			
Bank Name	City	State	
Include Your Checking or Savings Account Number in the Boxes Below:			
Account Number			

IMPORTANT

If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's prepayment fee and \$35 enrollment fee with this form and send them to Fortis Benefits.

This dental plan is provided by DentiCare, Inc. and administered by Fortis Benefits Insurance Company. Fortis Benefits will be the name referenced on your bank statement. This is not an insurance plan.

Prepayment fee is deducted from your authorized account on the 15th of the month prior to the month of benefits.

Plan automatically renews after 12 months.

This authorization is to remain in full force and effective until Fortis Benefits has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature _____ Date _____

John M. Doe Mary J. Doe 210 East Myntstreet Youngstown NJ 07095	_____ 20 _____	3780
Pay to the ORDER OF		3-6-340
		DOLLARS
VOID		
CP CENTRAL NATIONAL BANK Youngstown, NJ		
Memo		
A031000095 285 414 3A 3780		