

Plan 100 (SC1)

Plan 200 (SC2)

PLEASE PRINT

Social Security No. - -	Last Name	First Name	Initial
Street Address	City	State	Zip Code
		Home Phone No. ()	
Date of Birth MM/DD/YY / /	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Full-Time Employment MM/DD/YY / /
Employer	City	Work Phone No. ()	

Please complete the following for all family members enrolling in the dental plan.

You may select a Network General Dentist, Orthodontist, and Vision provider for each family member (up to 3 general dentists, orthodontists, and vision providers per family).

Last Name	First Name	MI	Sex	Date of Birth MM/DD/YY	Social Security #	Dentist #	Ortho #	Vision #
DO NOT COMPLETE								
<i>SELF</i>								
<i>Spouse</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #1</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #2</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #3</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #4</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #5</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #6</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
<i>Dependent Child #7</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			

I wish to enroll in the SmileChoice Plan as an individual. I understand that all necessary dental and vision services will be charged as described in the Description of Benefits and Copayments. By signing this form, or by paying a premium to SmileChoice for coverage for myself and/or eligible dependents, I agree to accept the terms of the SmileChoice Plan Contract and Evidence of Coverage.

Signature _____

Date / /

ANNUAL PAYMENT - I wish to pay my annual premium in full

1. Check Make Check or Money Order payable to SmileChoice
 2. Credit Card VISA Mastercard AMEX Discover

Credit Card Number: _____ Exp. _____

	Plan 100	Plan 200	
Member only	\$69.00	\$177.00	
Member & one dependent	\$108.00	\$258.00	\$ _____
Family	\$135.00	\$354.00	
One-time only application fee (non refundable)			\$10.00
TOTAL AMOUNT PAID/ENCLOSED			\$ _____

Make check payable and mail completed application to:

AUTOMATIC MONTHLY PAYMENT - I wish to pay my premium automatically monthly

1. Credit Card VISA Mastercard AMEX Discover
Upon receipt of application, first month's premium and application fee will be charged.

Credit Card Number: _____ Exp. _____

2. Automatic Checking Account Deduction **Enclose a Check (No Money Order) payable to SmileChoice for first month's premium and application fee along with a voided check.**

	Plan 100	Plan 200	
Member only	\$6.50	\$16.25	
Member & one dependent	\$10.00	\$24.00	\$ _____
Family	\$12.50	\$32.75	
One-time only application fee (non refundable)			\$10.00
TOTAL AMOUNT PAID/ENCLOSED			\$ _____

I hereby authorize SmileChoice to debit my checking account, or charge my credit card, each month the applicable monthly premium to be credited to my SmileChoice membership. This authorization will remain in effect until I notify Plan in writing, thirty (30) days prior to termination. My bank is authorized to make any necessary corrections. I understand that I will be charged \$10 for any declined or returned debit.

Member's Name (please print) _____

Account Holder's Name (please print) _____

Account Holder's Signature _____ Date / /

Agent Code: A5673

Agent Name: Marsha Andrews

It's easy To join *SmileChoice*™!

1. Use the attached enrollment form. Select the plan that best suits your needs, either Plan 100 or Plan 200.
2. Fill in your name, address, and phone numbers.
3. List yourself, spouse, and any eligible dependent(s) you wish to enroll. Complete the brief information request about you. Select a participating dentist, orthodontist, and vision care provider from the SmileChoice directory and write the office numbers in the spaces indicated. Select a maximum of three (3) dental, ortho and vision office locations per family (one (1) doctor per member, three (3) per family.)
4. Sign and date where indicated to authorize enrollment.
5. Select the payment plan you want by marking the appropriate box on the enrollment form.
 - To choose annual payment, enclose a check or money order, made payable to SmileChoice, or provide your VISA, Mastercard, AMEX or Discover information.
 - To choose automatic monthly payment by credit card, just indicate the type of card by checking the appropriate box, fill in the card number with expiration date, and sign the "automatic payment authorization". All future payments will automatically be charged to your VISA, Mastercard, AMEX or Discover.
 - To choose monthly payment by automatic checking account deduction, simply check that box on the enrollment form, sign the "automatic payment authorization" and enclose a check made payable to SmileChoice that includes the first months premium and the one-time only, non refundable \$10.00 enrollment fee along with a "voided" check. All future payments will automatically be deducted from your checking account.
6. Make certain all requested information has been provided and that the application is signed. Then mail - it's that easy!

Mail to:

If we receive your application before the 20th of the month, your coverage will begin the first day of the following month. If we receive your application after the 20th, your coverage will begin on the first day of the second month thereafter.