

Dental 160 Plan Individual Member Enrollment

PacifiCare[®]
Dental

INSTRUCTIONS FOR COMPLETING ENROLLMENT FORM

- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Subscriber:** Fill out section completely. Remember to indicate the **Provider Group Number/Dentist/City** you have selected.
- **Dependents:** All dependents you wish to be covered should be listed in this section with their selected **Provider Group**. Don't forget to indicate their **Provider Group Number/Dentist/City** selections.
- **Method of Payment:** Please indicate your preferred method of payment, Monthly Auto Pay or Annual Payment. Should you choose the Monthly Auto Pay option, complete and sign the Pre-Authorized Payment Application on the adjacent page. PacifiCare Dental will then automatically deduct the monthly premium from your checking account. Or, if you select the Annual Payment option, please include a check made payable to PacifiCare Dental for the annual premium and one-time enrollment and processing fee of \$15.00.
- **Terms and Conditions:** Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of the sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

SUBSCRIBER (You)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name		First Name		MI	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number		Home Phone ()
Mailing Address		City	State	ZIP	Work Phone ()
Provider Group Number	Dentist's Name/City		Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		

DEPENDENTS (Your spouse and/or children)

1	Relationship (spouse, daughter, son)	Last Name	First Name	MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2	Relationship (spouse, daughter, son)	Last Name	First Name	MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3	Relationship (spouse, daughter, son)	Last Name	First Name	MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4	Relationship (spouse, daughter, son)	Last Name	First Name	MI	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number	
	Provider Group Number	Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No		

METHOD OF PAYMENT

Monthly Auto Pay

Complete the attached **Pre-Authorized Payment Application** and include a **voided check**. A one-time non-refundable enrollment and processing fee of \$15.00 will be debited from your checking account along with your first month's premium.

*or save
when you
select the
Annual
Payment
Option...*

Annual Payment

Include a check payable to **PacifiCare Dental** for your annual premium. In addition to the annual premium amount, please include a one-time non-refundable enrollment and processing fee of \$15.00.

I understand and agree to the terms and conditions on the adjacent page.

X

Enrollee Signature

Date

Mail to:

Attn: M.E. Andrews and Associates
8190 E. Kaiser Blvd. Suite 100
Anaheim Hills, CA 92808

Tel (877) 433-7868

Fax (714) 279-1990

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- **Remember to select a provider!**
- **Be sure to read the terms and conditions below and sign in the box at the "X."**

TERMS AND CONDITIONS (Please read and sign on adjacent page)

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than \$5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than \$5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in PacifiCare Dental both member (including any heirs or assigns) and PacifiCare entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage.

PRE-AUTHORIZED PAYMENT APPLICATION

Complete this section only if you want your monthly premium automatically deducted from your checking account.

Our Pre-Authorized Payment Plan

It's the forget-proof method of paying your premium — almost as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no more paperwork for you and no more checks to write. No worries about monthly late-payment charges. And you'll save on postage and envelopes. It's easy, reliable, and automatic.

Authorized Agreement for Pre-Arranged Payments (Debits)

I (we) hereby authorize PACIFICARE DENTAL to initiate debit entries to my (our) checking account indicated below, and the bank named below, herein called BANK, to debit the same to such account.

Account No. (please enclose one voided check) _____

Bank Name _____ Bank Phone _____

Street Address _____

City _____ State _____ ZIP _____

This authority is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name (print clearly) _____ Social Security No. _____

Signature _____ Date _____

AGENT AND BROKER USE ONLY

Agent Name	Agent Number	Agent Phone
Marsha E. Andrews	8110	(714) 282-5980
Agent Address	City	State ZIP
8190 E. Kaiser Blvd. Suite 100	Anaheim Hills	CA 92808