AREA 2-CENTRAL/NORTHERN-PLAN GE400/GE600 ENROLLMENT FORM

1 MEMBER INFORMATION (PLEASE PRINT)

LAST NAME	FIRST NAME	HOME PHONE ( )	WORK PHONE ( )
HOME ADDRESS		CITY	STATE	ZIP CODE

SOCIAL SECURITY #	BIRTHDATE	SEE PROVIDER DIRECTORY FOR I.D. CODES:	DENTAL CODE	ORTHO CODE	VISION CODE

2 PURCHASER'S INFORMATION (COMPLETE ONLY IF DIFFERENT THAN MEMBER INFORMATION)

LAST NAME	FIRST NAME	HOME PHONE ( )	WORK PHONE ( )
HOME ADDRESS	CITY	STATE	ZIP CODE

3 PROVIDE ALL INFORMATION FOR EACH ELIGIBLE PERSON TO BE COVERED.

(Children under age 19. For children 19 - 23 and full-time student, provide proof of student status.)

SEE PROVIDER DIRECTORY FOR I.D. CODES:

LAST NAME	FIRST NAME	REQUIRED BIRTHDATE	REQUIRED SOCIAL SECURITY #	DENTAL CODE	ORTHO CODE	VISION CODE
SPOUSE		/ /	- -			
CHILD		/ /	- -			
CHILD		/ /	- -			
CHILD		/ /	- -			
CHILD		/ /	- -			

4 PAYMENT METHOD

- ☐ Monthly By Credit Card complete Sections 4, 5, & 7
- ☐ Annual By Credit Card complete Sections 4, 6, & 7
- ☐ Visa ☐ MC ☐ Discover/NOVUS ☐ AMEX

Card # ______________________________ Exp __________

Name on Credit Card ______________________________

Signature for credit card purchase ______________________________

- ☐ Monthly Automatic Bank Debit complete Sections 5 & 7 (To begin automatic bank debit, enclose a check for first month's premium plus application fee)
- ☐ Annual by Check complete Sections 6 & 7
- ☐ Annual by Money Order complete Sections 6 & 7

MONTHLY

5 Dental with Vision

	☐ Plan GE400	☐ Plan GE600	
Member only	$17.50	$7.15	$__________
Member & one (1) dependent	$25.70	$10.90	$__________
Family	$35.00	$13.50	$__________

I decline Signature Vision Plan (deduct $0.50) - .50

(50¢ per month covers one, two, or entire family)

One-time application fee (non-refundable) +$16.00

TOTAL AMOUNT ENCLOSED $__________

Enclose check or credit card number for payment that covers first month's premium + application fee.

Sign automatic payment authorization to authorize monthly deductions.

AUTOMATIC PAYMENT AUTHORIZATION: I hereby authorize Greater California Dental Plan (GCDP) to debit my checking account or charge my credit card each month the applicable monthly premium to be credited to my SmileSaver Dental Plan membership. This authorization will remain in effect until I notify GCDP, in writing, 30 days prior to termination. My bank is authorized to make any necessary corrections. I understand there is a nonrefundable service charge of 50 cents included in the monthly premium.

Name as it appears on check or credit card: (print)

____

Signature:

____

Date ______________

Proceed to Section 7 Acknowledgement.

ANNUAL

6 Dental with Vision

	☐ Plan GE400	☐ Plan GE600	
Member only	$199.00	$76.00	$__________
Member & one (1) dependent	$295.00	$121.00	$__________
Family	$404.00	$147.00	$__________

I decline Signature Vision Plan (deduct $6.00) - 6.00

($6 annually covers one, two, or entire family)

One-time application fee (non-refundable) +$16.00

TOTAL AMOUNT ENCLOSED $__________

Enclose check, money order or credit card number for payment to cover premium + application fee.

7 ACKNOWLEDGEMENT

(Be sure to sign to complete enrollment.)

I WISH TO ENROLL IN THE SMILESAVER PLAN AS INDICATED. I ACKNOWLEDGE THAT I HAVE READ THE ENCLOSED INFORMATION. I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS TRUE AND COMPLETE. I AGREE TO BE BOUND BY THE TERMS AND CONDITIONS OF THE SMILESAVER PLAN. BY SIGNING THIS CONTRACT, I AM AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND I AM GIVING UP MY RIGHT TO A JURY OR COURT TRIAL. (SEE THE GRIEVANCE PROCEDURE SECTION IN THIS DISCLOSURE FORM.)

Member's Name ______________________________
PLEASE PRINT

Member's Signature ______________________________

Date ______________

Agent Code#: M313 Agent Name: Marsha Andrews

Agent Phone: 1-877-433-7868 FOR INTERNAL USE ONLY

Mail to: M.E. Andrews & Associates Insurance Agency
8190 E. Kaiser Blvd., Ste. 100
Anaheim, CA 92808

DETACH HERE