

Plan Enrollment Form. You must return the Enrollment Form fully completed to be eligible. Each person must enroll in this dental program for a minimum of one year. Plan reserves the right to transfer patient to the nearest dentist office if anyoffice receives an insufficeint enrollment.

Benefits Unlimited Insurance Services
PO Box 3119
San Rafael, CA 94912
(415) 459-5019 Fax:(415) 459-2124

Social Security No.	Last Name	First	Initial	Mo.	Day	Yr.	Male <input type="checkbox"/>	Female <input type="checkbox"/>	PAYMENT CHOICE <input type="checkbox"/> 1199/1187 GOV'T PAYCHECK <input type="checkbox"/> BANK AUTH PLAN <input type="checkbox"/> ANNUAL PAYMENT
Home Address							Birthdate <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Name and Address of Employer or Organization				Job Title			PLAN CHOICE <input type="checkbox"/> 500 A <input type="checkbox"/> 500 B <input type="checkbox"/> 100 Money Saver <input type="checkbox"/> Plan 1		
Telephone Number (Home)				Date Hired					
LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW									
Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr.	Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr.
2. Spouse					5.				
3. Child					6.				
4.					7.				

Does Spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No With whom? _____ If answer is "Yes" are dependents enroled under spouse's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	OFFICE USE ONLY	GROUP #	EFFECTIVE DATE
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I UNDERSTAND THIS CONTRACT IS FOR A MINIMUM OF TWELVE MONTHS, AND RENEWED FOR TWELVE MONTHS PERIODS THEREAFTER. PLAN REQUIRES THIRTY DAYS WRITTEN NOTIFICATION OF INTENT TO CANCEL, AND IN THE EVENT OF SEPERATION OR TERMINATION, I AGREE TO PAY THE BALANCE OF ANNUAL PREMIUMS.

 X
 MEMBER'S SIGNATURE _____

DATE _____

BANK AUTHORIZATION PLAN

It's the mistake-proof method of paying your premiums -- 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 paper work for you and no more checks to write. It's easy, reliable, and automatic.

Authorization Agreement for Prearranged Payments (Debits)

Account # _____
(Please attach one voided check)

I (we) hereby authorize Benefits Unlimited Inc. to initiate debit entries to my (our) checking account indicated below, and the bank or credit union named below, herein called BANK, to debit the same to such account.

Bank Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone # of BANK _____

This authorization 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 manner as to afford BANK a reasonable opportunity to act on it. This authorization includes authority for increases in the program for as long as I remain a member in the program. A customer has the right to have the amount of an *erroneous* debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after charge, whichever comes first.

Name: _____
Signature: _____
Date: _____
Social Security # _____