

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							Sex			
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		Dental Center No. (If Applicable) _____	
Telephone Number (Home) _____ (Work) _____				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? _____			OFFICE USE ONLY		GROUP #	EFFECTIVE DATE
If answer is "Yes" are dependents enroled under spouse's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No										

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 _____

