SmartSmile[sm] Enrollment Form

Primary Subscriber Information

You can also enroll online at www.smartsmile.com/2000

Last Name | First Name | M.I. | Gender | Marital Status | Preferred Language

Address | City | State | Zip Code | Email | Employer

Home Phone | Work Phone | Birth Date | Requested Effective Date | Dentist Number
Listed next to your dentist's name in our Directory of Participating Dentists

ENROLLEES TO BE COVERED

Last Name	First Name	M.I.	Gender	Birth Date	Relation to Subscriber

Dependents include your spouse, domestic partner and/or children under 26 years of age. Children 26 years of age and over are eligible only while the child is and continues to be both 1) incapable of sustaining employment by reason of developmental disability or physical challenge, and 2) is chiefly dependent upon the subscriber for support and maintenance, provided proof of incapacity and dependency is furnished to Dental Health Services within 31 days of such a request but not more frequently than annually after the two-year period following the child's attainment of 26 years of age.

Choose Your SmartSmile[sm] Plan

SmartSmile	Monthly	Annually
☐ Subscriber	$17.75	$213.00
☐ Subscriber & 1 dependent	$35.00	$420.00
☐ Subscriber & 2 dependents	$47.75	$573.00
☐ Subscriber & 3+ dependents	$62.00	$744.00

Super SmartSmile	Monthly	Annually
☐ Subscriber	$24.25	$291.00
☐ Subscriber & 1 dependent	$47.25	$567.00
☐ Subscriber & 2 dependents	$62.50	$750.00
☐ Subscriber & 3+ dependents	$80.75	$969.00

Choose Your Payment Method and Include Payment

☐ 1. Check or money order - annual payment

☐ 2. Checking withdrawal - automatic monthly payments*

☐ 3. Credit card - annual payment

☐ 4. Credit card - automatic monthly payments*

☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number | Expiration

Amount (Annual or 2-months' Premium) | 3-Digit Code

Signature | Date

It is a crime to knowingly provide false, incomplete, or misleading information to a limited healthcare service contractor for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits.

*Monthly payments require an initial 2-month payment, with the second month's premium held by Dental Health Services, and used if automatic withdrawal is unavailable due to insufficient funds.

The account information on the enclosed check or listed credit card number is the account from which your premium payment will be withdrawn. Automatic checking withdrawal or monthly credit card charges begin the month following your eligibility date, and continue on or after the fifth of each month you are enrolled. **By selecting payment option 2 or 4, you hereby authorize Dental Health Services to withdraw the applicable monthly payment from your account. Monthly memberships renew automatically. Cancellation requests must be received in writing and must be signed by the primary subscriber. Cancellation requests received by the 15th of the current month will be effective the first of the following month.**

By submitting this form I authorize my dentist to release any information regarding my patient history to Dental Health Services, consulting professionals, or other designated or approved entities for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am over 18 years of age. **I agree that if I cancel my membership within the first year I will be subject to a $50.00 cancellation fee and will receive a pro-rated refund, if applicable.**

OFFICE USE ONLY

Eff. Date	Cycle	Group#	Plan#	P/S#	I.A.#	Agent Name	Agent#
A	M					Connexion Ins	2000