ENROLLMENT FORM FOR PREPAID DENTAL PLAN SERVICES

Write the number of the General Practitioner's office # you desire in the appropriate space below.

LAST NAME:	FIRST NAME:	DOB:	SOCIAL SECURITY #:

General Practitioner's Office #:

ADDRESS:	EMPLOYER:	
CITY, STATE, ZIP:	HOME PHONE:	WORK PHONE:

I hereby apply for Dental Health Plan membership for myself, and my family dependents listed hereon, and agree that we shall abide by the provision of the Dental Service Agreement and Health Plan Regulations.

I certify that the dependents listed hereon are supported by me and reside in my household, or are otherwise eligible as defined in the Service Agreement.

MINIMUM ENROLLMENT PERIOD

Each subscriber must agree to remain on the program a minimum of 1 year and 1 year periods thereafter.

Members must request cancelation, in writing, 30 days prior to the requested termination date.

ELIGIBLE DEPENDENTS

LAST NAME:	FIRST NAME:	RELATION:	DOB:
LAST NAME:	FIRST NAME:	RELATION:	DOB:
LAST NAME:	FIRST NAME:	RELATION:	DOB:

SIGNATURE:

Administrator's Use Only

Mail this enrollment form along with your Automated Clearing House form.

AUTOMATED CLEARING HOUSE Form

ADDRESS AND BANK CHANGES:

Please notify Integrity Administrators of any change in your home address, bank, bank account number, or bank routing number to avoid disruption in your coverage.

PAYMENT AUTHORIZATION:

Complete the authorization form below and we will deduct your contribution automatically from your account on or before the 10th of the month preceding your coverage month.

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PLEASE RETURN THIS PORTION WITH YOUR ENROLLMENT FORM

I authorize the following amount to be withdrawn from my bank checking or savings account listed below to pay my monthly contributions for the Prepaid Dental Plan coverage.
(PLEASE CHECK APPLICABLE BOX)

☐ Member only - $25.00 ☐ Member and Dependents - $44.25

BANK NAME ______________________________ **ACCT#** _________________________

BANK ROUTING# ______________________________
(Routing number is usually located at the bottom of your check just before the account number. If unsure, please send a "**VOIDED**" check with this form.)

NAME (print): _________________________________ **Signature** ____________________

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Mail this payment authorization form along with your Prepaid Enrollment form to:

INTEGRITY ADMINISTRATORS, INC.
P O Box 13128
Sacramento, CA 95813-3128