Dental Health Services Inc.

Your Dental Plan Enrollment Form

YOU CAN ALSO ENROLL ONLINE AT DENTALHEALTHSERVICES.COM

You're only a few steps away from a healthier and smarter smile! Simply compare plans, select which plan is right for you and/or your family, fill out the form, complete your payment information, and that's it! It really is that simple.

Step 1: Complete Your Information (All fields are required)

Subscriber

(a person whose relationship as the primary enrollee is the basis for coverage under this agreement)

First Name | Last Name | M.I. | Gender | Marital/Domestic Partnership Status

Preferred Spoken Language | Preferred Written Language | Ethnicity

Address | Apt. # | City | State | Zip Code

Primary Phone | Cell Phone | Employer | Email

Birth Date (mm/dd/yyyy) | Requested Effective Date* (mm/dd/yyyy) | Dentist Number

* enrollment will be effective the 1st of the month following receipt of this form, unless a future date is requested

Listed next to your dentist's name in our Directory of Participating Dentists.

Enrollees to be Covered

Include Subscriber if coverage is also needed

(please include additional enrollees on a separate sheet of paper, if needed)

Use Disability Codes Below

First Name	Last Name	MI	Gender	Birth Date (mm/dd/yyyy)	Relationship to Subscriber	Language	Disability

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.

Disability Codes:

A. Physical impairment. **B.** Mental impairment **C.** Blindness or low vision **D.** Deafness

Please return completed form to Dental Health Services: 100 W. Harrison St. Suite 440 South Tower Seattle , WA 98119

Step 2: Choose Your SmartSmile-EC℠ Plan

INDIVIDUAL COVERAGE	SmartSmile-EC℠	Super SmartSmile-EC℠	SmartSmile Plus-EC℠
	MONTHLY	MONTHLY	MONTHLY
	Premium	Premium	Premium
Pediatric Child* (18 years old & under)	[$24.80]	[$24.75]	[$28.45]
Young Adult (19-25 years old)	[$20.30]	[$24.60]	[$24.60]
Adult (26 years old & over)	[$21.90]	[$26.65]	[$26.65]
TOTAL (Premiums x no. of enrollees)			

*Maximum of three pediatric children will be charged

Step 3: Provide Your Payment Information

(1st monthly premium will be charged when this form is processed.)

- ☐ Check or money order
- ☐ Checking withdrawal - automatic monthly payments
- ☐ Credit card - automatic monthly payments
  - ☐ Visa
  - ☐ MasterCard
  - ☐ Discover

Account Number _____ Routing Number _____

Credit Card Number _____ 3-Digit Code _____

Amount _____ Expiration (mm/yy) _____

By selecting a monthly payment option, you hereby authorize Dental Health Services to withdraw the applicable monthly invoice balance from your account. The account information on your enclosed check or listed credit card number will be the account from which your premium payment will be withdrawn monthly. Your monthly charge for subsequent months will be deducted between the 23rd and 28th day of the month prior to that month of service. For example, if you owe premium for February, your payment would be taken between the 23rd and 28th day of January. Monthly memberships renew automatically. Termination requests may be submitted by calling **800-637-6453** or in writing signed by the primary subscriber. Termination requests received by the 15th of the current month will be effective the first of the following month. Termination requests received on or after the 16th of the month will take effect the 1st of the second month following the request for termination. You will receive a pro-rated refund if applicable.

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 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.

You may be guilty of fraud and may be subject to civil or criminal penalties if you knowingly provide false, incomplete or misleading information to Dental Health Services for the purpose of defrauding the Dental Health Services.

Signature _____ **Date (mm/dd/yyyy)** _____

Dental Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: If you, or anyone who is helping you has questions about Dental Health Services, you have the right to obtain information in your own language without any cost to you. To speak with an interpreter, call **1-866-756-4259**.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Dental Health Services, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **1-866-756-4259**.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi vềDental Health Services, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi **1-866-756-4259**.

OFFICE USE ONLY	Eff. Date Cycle	Group #	Plan #	P/S #	I.A. #	Producer Name	Producer #