CAPDENT GROUP DENTAL APPLICATION

ALL NJ INSURED PLANS UNDERWRITTEN BY INTERNATIONAL HEALTHCARE SERVICES, INC.

EMPLOYER INFORMATION

Company Name____

Address____

City ______________________________State _________ Zip__________________

Contact Person ______________________Title______________ Phone______________

Group Census _________ Single__________ Two Party___________ Family ___________

Requested Effective Date ______/____1____/_______

BILLING PERIOD MONTHLY_______ QUARTERLY________ ANNUALLY_______ OTHER_______

All New Jersey groups should submit a copy of their most recent NJ-927 Tax Form.

Coverage for dependents on the CapDent dental plan ends at age 19, or 25 if full-time student. Coverage will begin on the first of the next month if the application, enrollment cards, and payment are received by the 15th of the current month. **Groups *of two or more enrolled will be billed monthly – groups of one will be billed annually*.** Premiums are due and are payable at the beginning of each billing period. Please include the first period's premium (payable to ***International Healthcare Services, Inc***.) along with this application. Thank You!

Signature ________________________Title___________________ Date____/______/_____

BROKER INFORMATION

Sales Representative

Address

City, State, Zip

Phone ( ) Fax ( )

Social Security # *or* Tax ID #

FOR INTERNAL USE ONLY

GROUP #________________________________ Actual Effective Date______/___1___/______