

NEW JERSEY CAPDENT DENTAL PLANS – MONTHLY RATE AND PAYMENT FORM

F-2120

Please select one plan

CapDent [] Single \$153.60
 (Non Group) [] Family \$381.60
Annual Billing

CapDent [] Single \$12.80
 (Group) [] Two-Party \$25.65
 [] Family \$36.65

Group Billing available on Monthly basis

Check enclosed in the amount of \$ _____ payable to Healthplex, Inc.

Please select one method of payment

VISA or MASTERCARD (circle one)
 Monthly authorization until canceled by me in writing in the amount of \$ _____

Name _____ Card # _____ Exp. Date _____

Signature _____ Date _____

MAIL TO: HEALTHPLEX, INC, 60 CHARLES LINDBERGH BLVD, UNIONDALE, NY 11553

To enroll on the 1st day of a given month, enrollment materials must be received by the 15th day of the preceding month.

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

1/01/01

NEW JERSEY CAPDENT DENTAL PLANS – ENROLLMENT CARD

Last Name _____ First Name _____ M.I. _____

Date of Birth _____ Social Security # _____

Address _____

Home Telephone # _____ Office Telephone # _____

City, State, Zip _____

Group Name _____ Group # _____

DEPENDENTS

(If Two-Party or family coverage is selected)

Check Relationship Spouse Son Dtr Birth Date

	Spouse	Son	Dtr	Birth Date
				/ /
				/ /
				/ /
				/ /
				/ /

Plan Selection

CapDent – (Select Provider)

Please enter the Dentist's Name and Code Number from our list of providers:

Dentist Name: _____

Dentist Code: _____

*I understand that Benefits are only available at participating dental offices.

SIGNATURE _____ DATE _____

I agree to maintain my enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a twelve month period.

-OVER-