



HEALTHPLEX

Dental Plan Enrollment Form

FOR DENTAL PLANS BY DENTCARE DELIVERY SYSTEMS, INC., INTERNATIONAL HEALTHCARE SERVICES, INC., HEALTHPLEX INSURANCE COMPANY, OR HEALTHPLEX, INC.

Employee Information section containing fields for Last Name, First Name, M.I., SSN/ID Number, Address, City, State, Zip Code, Home Phone, Work Phone, Gender, D.O.B., Employer Name/Group, Group Number, Effective Date, Date of Hire, and Other Dental Coverage options.

Group Plan Selection section with checkboxes for various dental plans including CapDent New York, CapDent Plus New York, CapDent Plus Ultra, Preferred Choice Plan, CapDent Select, CapDent New Jersey, CapDent Plus New Jersey, CapDent Select Plus, Omni PPO, Healthplex Insurance Company Plan, Comprehensive Voluntary, Low Option, Medium Option, High Option, and High Enhanced Option.

Coverage Selected and Dental Selection section with checkboxes for Single, Two Party, Family coverage and fields for Dentist Name, Dentist Site Code, and a note for Managed Care Plans.

Dependents To Be Covered section with a table for listing dependents including Last Name, First Name, M/F, Spouse/D.P., Son, Dtr, and D.O.B.

*There is an additional monthly premium of \$10.00 for each family member in excess of five (5).

Signature and Date fields.

Broker Information section with fields for Broker Name and SSN/Tax ID #.

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

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