

MetroCare Dental Plan Enrollment Form



MetroCare Dental Plan LLC
14285 Midway Road, Suite 160, Addison, TX 75001

Account Number	Effective Date
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Please print or type. Shaded areas are for producer or office use only.

1 The discount plan I am applying for is...

- MetroCare Dental Plan MetroCare Dental Plan - Elite

2 I'm filling out this application because I wish coverage for...

- Myself Only Myself & the dependents listed below

3 My information is...

Self (Last, First, Middle Initial)	Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address	City/State/Zip	Home Telephone Number
E-mail Address	Date of Birth	Requested Effective Date

4 My annual payment will be paid by the following method:

- Credit Card (Master Card/Visa, Amex, Discover) Personal Check (please send by mail)
- Card number _____ Exp Date _____ / _____ Signature _____

I authorize the verification of the information provided on this form as to my credit card and understand that my card will be billed annually. I am responsible for any changes to my information and will give written notice at least 60 days prior to cancellation of my membership. I understand if I do not provide a 60 day written cancellation, my credit card will be billed the full amount of the annual membership fee.

5 I want to enroll my...

Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Social Security Number	<input type="checkbox"/> Husband/Wife <input type="checkbox"/> Domestic Partner
Dependent Child (Last, First, Middle Initial)	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Social Security Number	
Dependent Child (Last, First, Middle Initial)	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Social Security Number	
Dependent Child (Last, First, Middle Initial)	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Social Security Number	

I, the undersigned, have fully read, understand and agree to all terms and agreements and I attest that the above statements are true and correct. With my signature I attest to the accuracy of the information provided on this form and acknowledge my desire to enroll in the MetroCare Dental Plan.

Signature: _____ Date: _____

<i>For Office Use Only:</i>	<i>Online</i>	<i>Date Received</i>
<i>Renewal Date</i>	<i>Referral Source - Location</i>	<i>Member Number</i>