



ENROLLMENT FORM

Requested Effective Date _____

First Name Initial Last Name

Date of Birth _____ AGE _____ Gender ___ male ___ female

Social Security Number _____

Cell Number _____

Email address _____

Address _____

City _____ State _____ Zip _____

If you pay via EFT from Bank Account you will receive a \$3.00 monthly discount which is already included in the rates

Banking Name _____

Routing Number _____

Account Number _____

Do you Currently Have Dental Now? ___ NO ___ YES If so, who is your policy with

Your Primary Care Dental Porvider _____

Address _____

City _____ State _____ ZIP _____

Phone Number _____

SIGNATURE AUTHORIZATION: _____ DATE _____

Premier Plan

Preferred Plan

Standard Plan

Economy Plan

PLEASE ENROLL ME INTO THE PLAN SEKECTED.CHECKED OFF ABOVE

Return to Lynne Clausen (email: Lynne@InsAdvocates.com or Fax 863-588-1663