

Return this form to EDS



700N Enrollment Application & Agreement

Employers Dental Services

- New Enrollment
Payment Method - Monthly Pay
Payment Method - Year Pay

Enrollment Information

Form fields for enrollment information including Last Name, First Name, MI, Daytime Telephone, Mailing Address, Cell or work Telephone, City, State, ZIP Code, Social Security Number, Dental Facility Selected, ID number, Name of office, and Date of Birth.

(10) Do you wish to cover your eligible dependents? [] Yes [] No (11) Total number of dependents

(12) Dependents List all eligible dependents you wish to cover

Table with columns: Last Name, First Name, Middle Initial, Date of Birth (mm/dd/yyyy). Includes checkboxes for Domestic Partner and Spouse. Rows are labeled 'Child'.

(13) Agent/Broker Information

Form fields for Agent/Broker Information including BROKER name (Magnuson & Associates, LTD), EDS Rep, Broker # (54), and EDS#.

Eligibility:

Eligible dependents include lawful spouse, domestic partner and children to age 26. Domestic Partners are required to sign an Affidavit of Domestic Partners (call EDS to obtain a form). Members may add dependents mid-year if a marriage occurs. Dependent's newborn or adopted children will be eligible immediately upon birth or placement of adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be removed when they are no longer eligible. Benefits are available at an EDS contracted dental facility only.

I hereby agree to be bound by the terms of the EDS Individual Pre-paid Plan as set forth in the Dental Enrollment & Coverage Guide for EDS Individuals. I agree to remain in this plan for a minimum of one (1) year, EDS coverage is continuous and the subscriber (you) must notify EDS in writing to terminate the coverage. Reimbursement of premium is not available. I certify that the above information is correct.

Signature X _____ Date _____ (Member or Parent/Guardian)

Mailing address: EDS, 3430 E.Sunrise Dr. #160, Tucson, AZ 85718 EDSCS@principal.com 800-722-9772

How did you hear about us? [] Friend or Relative [] Dentist [] Employer [] Prior EDS Member [] Other

Internal Use Only Effective Date



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Bank Draft Authorization

Employers Dental Services

Mailing Address:
3430 E. Sunrise Dr. #160
Tucson, AZ 85718

Please print legibly

Bank Draft Authorization:

Monthly payments by credit card are not available.

Please complete this section to initiate monthly deduction from your bank account.

Bank name _____ Checking account Savings account

Routing number (Transit/ABA number) _____

Account number _____

ACH Debits: Employers Dental Services ID Number: 1860328922

I (we) hereby authorize Employers Dental Services, hereinafter called COMPANY, to initiate debit entries to my (our) bank account indicated above and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account.

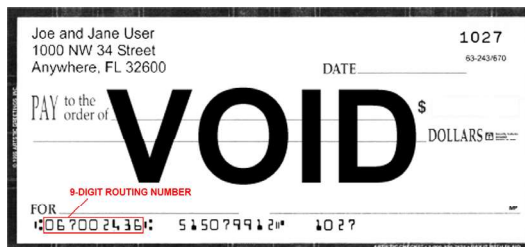
This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by DEPOSITORY, provided I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first. **All deductions will be made from your savings or checking account between the 15th and 20th of each month.** A return item charge will be accessed if an automatic deduction is returned unpaid; the amount of the charge will be at the rate in effect at the time the item is returned to EDS.

Signature _____ Date _____

Print Name _____ Phone _____

Please write VOID on a blank check and attach here

Example



For assistance call Customer Service at 800-722-9772



Return this form to EDS with payment

Payment Method Form 700N

| Employers Dental Services |

Yearly Payment

| 700N | Cost for 1 year |
|---------------------------------|-----------------|
| Adult Only | \$209.28 |
| Adult + 1 dependent | \$344.16 |
| Adult + 2 dependents | \$447.72 |
| Adult + 3 or more dependents | \$555.24 |
| Child Only (to age 18) | \$140.88 |
| Payment MUST be enclosed | \$ |

Pay yearly premium with credit card, check or money order payable to EDS.

Charge my credit card: M/C Visa Am Ex Discover

Account # _____

Expiration ____ / ____ Signature Code _____

Signature of card holder _____ Date: _____

Print name & address of credit card holder:

Name Daytime telephone _____

Street

City State Zip

Send Payment

Mail to **EDS, 3430 E.Sunrise Dr. #160, Tucson, AZ 85718**

For assistance, call EDS Customer Service 800-722-9772.



Return this form to EDS with payment

Payment Method Form 700N | Employers Dental Services |

Monthly Payment – Bank Draft

| 700N | Cost for 1 st month* | Cost after 1 st month |
|--|---------------------------------|----------------------------------|
| Adult Only | \$28.36 | \$18.36 |
| Adult + 1 dependent | \$40.19 | \$30.19 |
| Adult + 2 dependents | \$49.27 | \$39.27 |
| Adult + 3 or more dependents | \$58.71 | \$48.71 |
| Child Only (to age 18) | \$22.14 | \$12.14 |
| 1st month's payment MUST be enclosed | \$ | |

*1st month's rates include a one-time \$10 administrative fee.

Pay 1st month's premium with credit card, check or money order payable to EDS.

Monthly payments by credit card are not available.

Charge my credit card: M/C Visa Am Ex Discover

Account # _____

Expiration ____ / ____ Signature Code _____

Signature of card holder _____ Date: _____

Print name & address of credit card holder:

Name _____ Daytime telephone _____

Street _____

City _____ State _____ Zip _____

Send Payment

Mail to EDS, 3430 E. Sunrise Dr. #160, Tucson, AZ 85718

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