



**INDIVIDUAL DENTAL MEMBERSHIP ENROLLMENT FORM**

**TO BE COMPLETED BY PRIMARY INSURED**

Social Security Number	Last Name	First Name	Middle Initial
Street Address	City	State	Zip
Mailing Address	City	State	Zip
Date of Birth	Phone #	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Coverage Start Date E-Mail Address
Do you currently have other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, with what insurance company?			
Policy #:      Group Number if applicable:			

**AGENT INFORMATION**

Agent Name <b>Jack Straus</b>	Agency Name <b>Straus &amp; Associates, Inc.</b>	Agent E-mail address <b>jack@strausandassociates.com</b>	Phone # <b>(541)857-8446</b>
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**DENTAL COVERAGE      MAXIMUM BENEFIT**

Tier: EO <input type="checkbox"/> ES <input type="checkbox"/> EC <input type="checkbox"/> EF <input type="checkbox"/>	Premium Amount: (please write in) \$	750 Max <input type="checkbox"/>	1000 Max <input type="checkbox"/>	1500 Max <input type="checkbox"/>
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**Billing Information**

Direct Bill (see contract for NSF policy)       Credit Card Bill (if choosing this option you must fill out credit card payment form)

**DEPENDENT**

LAST	FIRST	MI	SSN #	Gender	Date of Birth	Other Dental Coverage Policy Holder Id No.	Current Insurance Co.
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

I affirm that the answers in this application are complete and correct. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. If you provide an e-mail address correspondence will be sent to you via e-mail rather than regular mail.

Signature \_\_\_\_\_ Date:      /      /