



ODS Individual Dental Exchange Enrollment Application

Please complete both sides of this form and sign on the back. Please type or print legibly in dark blue or black ink.

Applicant Name First M.I. Last			Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Applicant Social Security No.
Applicant Mailing Address City State ZIP			Home Telephone No.		

Are you a resident of Oregon? Yes No

(In order to be eligible to enroll in this plan, you must be an Oregon resident and live in Oregon for at least six (6) months out of the year.)

When did your employer-sponsored group dental plan terminate? _____

Please write your employer name: _____

Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage? Yes No

If yes, please provide the following:

1. Name of individual enrolled in prior plan: _____

2. Carrier name: _____ Carrier telephone number: _____

OR Effective: ___ / ___ / ___ Termed: ___ / ___ / ___

3. Copy of prior dental plan ID card, front and back.

Dependent Information (Dependents must have been covered under prior group plan in order to be eligible for continuation.)

Name First M.I. Last	Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	

Type of Application

New Enrollment

This application for dental insurance coverage is for:

Insured Only

Insured + Spouse

Family

Insured + Child(ren)

Individual Dental Eligibility Requirements

You are eligible for individual dental coverage under this agreement if you meet the following requirements:

- You had 12 months of continuous coverage on a group employer-sponsored dental plan, which met minimum coverage requirements as stipulated.
- You are applying within 90 days from the date your employer-sponsored plan terminated.
- You are an Oregon resident and live in Oregon at least six months out of the year.

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ODS Enrollment Application *It is very important that you sign and date below.*

Billing Information: Choose One Option

Monthly Premium: Insured only: [] Insured + Spouse: [] Family: [] Insured + Children: []

Option 1: Auto Pay Plan (checking account deduction)

Bank Name: _____ Branch: _____
Bank Address: _____ Bank Account No.: _____

This authority is to remain in full force and effect until ODS and my bank have received written notifications from me of its termination in such time and in such manner as to afford ODS and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such an error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

- Attach a check for one month's premium made payable to ODS.
- Attach a "voided" check from which you want the payment withdrawn.
- Funds will transfer on or around the fifth calendar day of each month.

Signature: _____ Date: _____

Option 2: Monthly Billing Statement

- A \$2 monthly administration fee is required with this payment method.
- Attach a check or money order for one month's premium made payable to ODS. A bill will be sent in the mail every month.

Signature: _____ Date: _____

Option 3: Quarterly Billing Statement (self-pay)

- Attach a check or money order for three months' premium made payable to ODS.

Signature: _____ Date: _____

For Agent Use Only

I, (the Agent) certify I have explained the eligibility provisions to the Applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by ODS, and provided Oregon Disclosure Information required. I CERTIFY THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name (please print or type): _____ Agent Tax ID No.: _____

Agency Name: _____ Telephone No.: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Agent Signature (required): _____ Date: _____

Agent: Collect Premium with Application

I understand mailing a check to ODS does not guarantee coverage. My premium payment will not be credited to my account unless my application for the ODS Individual Dental Exchange Plan has been received by ODS within the 90-day period following my loss of an employer-sponsored dental plan or the 90-day period following the beginning of my employer-sponsored medical plan. If ODS receives my application within this 90-day period, the effective date of coverage will be the 1st of the month following the receipt of my application. If my application is not received within the 90-day period following the loss of the employer-sponsored dental plan or the 90-day period following the beginning of my employer-sponsored medical plan, ODS will notify me in writing and my payment will be returned.

Signature: _____ Date: _____

