



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.

503-265-5696
800-852-5195, ext. 5696
www.odskompanies.com

Applicant name (first, middle initial, last)		Birthdate	Gender	Applicant Social Security no.
Applicant mailing address		City	State	ZIP
Home telephone no.		Email address		
Primary language		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		

- 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.)
- 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:
 - Name of individual enrolled in prior plan: _____
 - Carrier name: _____ Carrier telephone number : _____
 Effective: ___ / ___ / ___ Termined: ___ / ___ / ___

Dependent information <i>(Dependents must have been covered under prior group plan in order to be eligible for continuation.)</i>			
Name (first, middle initial, last)	Birthdate	Gender	Social Security no.
Spouse/Registered domestic partner*		<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	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	

*Registered domestic partner according to the Oregon Family Fairness Act.

Type of application

- New enrollment
- This application for dental insurance coverage is for:
- Insured only
- Insured + spouse or registered domestic partner*
- Family
- Insured + child(ren)

Individual Dental Exchange eligibility requirements

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

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

ODS Individual Dental Exchange 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, or indicate here if you want the initial premium drafted. Yes No
- 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 \$5 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.

Option 3: Quarterly billing statement

- A \$5 quarterly administration fee is required with this payment method.
- Attach a check or money order for three months' premium made payable to ODS.

For agent use only — reminder: collect premium with application

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): _____

Agency name: _____ Telephone no.: _____

Street address: _____ City: _____ State: _____ ZIP: _____

Agent signature (required): _____ Date: _____

Applicant signature

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 a qualified dental 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, or does not otherwise meet the eligibility requirements as stipulated, ODS will notify me in writing and my payment will be returned.

Signature: _____ Date: _____

Return your completed application using one of these methods:
MAIL: ODS Eligibility Department, 601 SW Second Ave., Portland, OR 97204
FAX: 503-219-3696 **EMAIL:** Scan and send to indunit@odscompanies.com

