

Application Instructions

Thank you for giving us the opportunity to help in your insurance request. We know that you have a choice of online insurance services and we appreciate that you chose us.

To submit your application:

1. Review the application for accuracy and completeness. You can make changes on the printed copy – Please initial your changes.
2. Sign & Date the application
3. Include the payment. Made payable to the insurance carrier
4. Mail your application to:

Assurance Benefits
PO Box 41454
Phoenix, Az 85080

It is necessary to mail us your application so we can:

- Review your application for completeness – An application submitted to the carrier that is not complete delays the process.
- Request any additional information the carrier requires
- Keep you informed during the underwriting process
- Let you know when your application has been approved and the effective date.

We will contact you immediately when your application arrives to clarify or complete.

Questions? Call 800-799-2893

Thank you and we look forward to working with you.



**Employers
Dental
Services**

Managed Dental Care Services

A Company of the
Principal Financial Group



EMPLOYERS DENTAL SERVICES (EDS) ENROLLMENT & AGREEMENT INDIVIDUAL PLAN

- New Enrollment
 Renewal
 Change of Family Status
 (Additional premium payment may be required)

Today's Date _____

Effective Date (internal use only) _____

Social Security	Last Name	First	Middle Initial
Mailing Address			
City		State	Zip Code
Home Telephone - with area code ()	Work Telephone - with area code ()	Date of Birth (MM/DD/YYYY)	
General Dentist Selection			

List all Eligible Dependents to be covered on your Dental Plan:

Last Name (If Different)	First Name	M	Date of Birth (MM/DD/YYYY)
Spouse _____	_____	_____	_____
1.Child _____	_____	_____	_____
2.Child _____	_____	_____	_____
3.Child _____	_____	_____	_____

Eligibility: Eligible dependents will include lawful spouse and unmarried children to age 19, or any unmarried children to age 25, who attend an accredited educational institution on a full-time basis and are fully dependent on the member for support. Members may add dependents mid-year if a marriage occurs. Dependent newborn or adopted children placed for adoption will be eligible immediately upon birth or upon placement for adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be deleted when they are no longer eligible.

CHANGE OF STATUS ONLY

Change of Name: Former Name _____

- Delete dependents shown above Add dependents shown above

Changes are effective the first of the month following receipt of the request. Additional premium may be due if you are adding dependents. Please call the Customer Service Department at 1-800-722-9772 for the amount of premium to be included with your request.

I hereby agree to be bound by the terms of the EDS Individual Prepaid Dental Plan as set forth in the Enrollment and Coverage Booklet for EDS Individual Plan. I agree to remain in this plan for a minimum of one (1) year. I certify that the above information is correct. I authorize any dentist or other dental care provider to furnish any representative of Employers Dental Services any and all records pertaining to dental history, services, or treatment of anyone enrolled for the purpose of review, investigation, or evaluation of an application or claim. This authorization is valid for 12 months from my effective date. A photocopy of this authorization shall be valid as the original. My authorized representative or myself are entitled to receive a copy of the authorization form.

Date: _____ Signature _____
Member or Parent/Guardian

Payment Method

- Monthly** – Automatic deduction from checking or savings account only.
Complete Sure Pay Authorization on the back of the Enrollment Form.
First months premium and \$10.00 set-up fee must accompany enrollment.

- Annual**
- Check Charge My Credit Card
 VISA MASTERCARD DISCOVER AMEX

Account # _____ Expiration Date _____

Date: _____ Signature: _____
Of Card Holder

Broker Name	Broker #	EDS Representative	EDS#
Assurance Benefits 623-780-0077	0776		

SURE-PAY AUTHORIZATION

To initiate "Sure-Pay" Authorization, complete the form below and include the first month's premium plus one-time enrollment fee



SURE-PAY AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS
(ACH DEBITS) Employers Dental Services ID Number 1860328922
INDIVIDUAL PLAN

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

BANK NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP CODE _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____

Checking Account

Savings 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 time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) has 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 13th and the 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.

NAME _____ SS NUMBER _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP CODE _____

SIGNATURE _____ DATE _____

ATTACH A VOIDED CHECK HERE

Return the premium amount and enrollment form to:

Assurance Benefits & Consulting
P.O. Box 41454
Phoenix, AZ 85080

For assistance call

Customer Service at 1-800-722-9772.

ENROLLMENT RECEIVED BY THE 15TH OF THE MONTH WILL BE EFFECTIVE THE FIRST OF THE NEXT MONTH