SeniorSelect Dental plan enrollment application

SUBSCRIBER NAME (First, middle initial, last)	**SOCIAL SECURITY NO.**	**GENDER**	**BIRTHDAY** (Month/day/year)	**TELEPHONE**
Residence address / City / State / ZIP			ODS Medicare plan effective date:	
Mailing address / City / State / ZIP			Primary language: ❑ English ❑ Spanish ❑ Other: ______	
Email address				

SELECT TO ACCEPT THE DENTAL PLAN:

☐ SeniorSelect Dental plan — $30 per month *I understand ODS must receive my application with a postmark date no later than the effective date of my ODS Medicare plan; and that if I do not elect this dental coverage now, the "one time only" ODS SeniorSelect Dental plan enrollment period will end and I will be unable to add the dental plan in the future. The ODS SeniorSelect Dental plan effective date will coincide with my ODS Medicare plan effective date. I agree to the terms of the contract with my signature selecting a billing option.*

CHOOSE A BILLING METHOD:

OPTION 1: ☐ **AUTO PAY PLAN** (CHECKING ACCOUNT DEDUCTION)

Bank name: ______ Account holder: ______

I, (or we, if this is a joint account) authorize ODS to charge my (our) checking account for monthly insurance premiums for the above named individual. I also authorize my bank, named here, to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged. (If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.)

Signature of account holder: ______ Date: ______

- 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- **Attach a "voided" check from which you want the payment withdrawn.**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.

OPTION 2: ☐ **MONTHLY BILLING STATEMENT**

- A $5 monthly administration fee applies to this payment method.
- **Please enclose a check or money order for one month's premium made payable to Oregon Dental Service**. A monthly bill will be mailed.

Signature: ______ Date: ______

OPTION 3: ☐ **QUARTERLY BILLING STATEMENT**

- A $5 quarterly administration fee applies to this payment method.
- **Please enclose a check or money order for three month's premium made payable to Oregon Dental Service.** A quarterly bill will be mailed.

Signature: ______ Date: ______

AGENT SIGNATURE (IF APPLICABLE):

Print, then sign: Dann Loewenthal Date: