Nevada Dental Benefits, Ltd. ®
a PRIMECARE™ BENEFITS GROUP company

# DENTAL PLAN ENROLLMENT FORM

## SUBSCRIBER INFORMATION

| | | | | |
|---|---|---|---|---|
| Please indicate your dental plan choice by marking the box with an "X" ☐ Subscriber (Head of Household) ☐ Subscriber +1 ☐ Subscriber +2 or More | | | | |
| Last Name | First Name | M.I. | Social Security Number | Date of Birth |
| Address | Apt. | City | State | Zip |
| Phone Number | Email | Sex ☐ Male ☐ Female | | |
| Plan ID | Employer | | | |

## SPOUSE

| | | | | |
|---|---|---|---|---|
| Last Name | First Name | M.I. | Social Security Number | Date of Birth |
| Sex ☐ Male ☐ Female | Marriage Date | Does your spouse have other dental coverage? If yes, complete information below. ☐ Yes ☐ No | | |
| Spouse's Employer Name | Effective Date | | | |
| Dental Insurance Name | Address | Phone Number | Policy # | |

## DEPENDENTS

| | | | | | |
|---|---|---|---|---|---|
| Last Name | First name | M.I. | Sex ☐ Male ☐ Female | Social Security Number | Date of Birth |
| Last Name | First Name | M.I. | Sex ☐ Male ☐ Female | Social Security Number | Date of Birth |
| Last Name | First Name | M.I. | Sex ☐ Male ☐ Female | Social Security Number | Date of Birth |
| Last Name | First Name | M.I. | Sex ☐ Male ☐ Female | Social Security Number | Date of Birth |

Are the dependents listed above covered under your spouse's dental insurance? ☐ Yes ☐ No

Are the dependents listed above covered under dental insurance, other than your spouse's? ☐ Yes ☐ No

## AVAILABLE PLAN OPTIONS

| NDB NEVADA KIDS SILVER + ADULT | SOUTHERN NEVADA RATES |
|---|---|
| Subscriber | $16.90 |
| Subscriber +1 | $33.80 |
| Subscriber +2 or More | $50.70 |

## PAYMENT METHOD

I prefer to make: ☐ One Time Annual (Payment in Full) ☐ Recurring Monthly (1st of Month) ☐ Monthly Payment Only

*If no option is selected, we will automatically deduct payments on a monthly basis using your selected payment method. You may change this option at anytime by contacting Nevada Dental Benefits, Ltd. at 702-478-2014 or 866-998-3944

### CREDIT CARD PAYMENT

| | | | |
|---|---|---|---|
| Credit Card (tick one) ☐ VISA ☐ ☐ DISCOVER ☐ | Credit Card # | Security Code (CVV) | Expiration Date (MM/YY) |
| Amount $ | Billing Address | | Billing Zip Code |

### ACH / ELECTRONIC CHECK PAYMENT | Please attach a voided check

| | | | |
|---|---|---|---|
| ☐ Checking ☐ Savings | Bank Name | Bank Routing Number | |
| Bank Account Number | Amount $ | Account Holder's Name | |

### CHECK PAYMENT

Please send your paper check along with this form to: ***Nevada Dental Benefits, Ltd.*** PO BOX 81950, Las Vegas, NV 89180

I hereby apply for coverage on the basis of the statements and answers to the questions above. I declare all answers to be true and complete. I understand that any incorrect statements made above may result in termination of coverage for my and/or dependent(s)' dental benefits. By my signature below, I acknowledge that Nevada Dental Benefits, Ltd. and its' authorized agents may use and disclose health information for purposes related to reviewing and processing my claims and my dependent(s)' claims, and authorize payment to Nevada Dental Benefits, Ltd. according to my preferred payment method.

Signature _____ Date mm/dd/yy

**Questions? Please call our customer care coordinators at 702-478-2014 or 866-998-3944 or email us at contactus@nevadadentalbenefits.com**

*For additional enrollees please use additional sheets**