Plan Enrollment Form. You must return the Enrollment Form fully completed to be eligible. Each person must enroll in this dental program for a minimum of one year. Plan reserves the right to transfer patient to the nearest dentist office if anyoffice receives an insufficeint enrollment.

Benefits Unlimited Insurance Services
PO Box 3119
San Rafael, CA 94912
(415) 459-5019 Fax:(415) 459-2124

Social Security No.	Last Name	First	Initial	Birthdate Mo. Day Yr.	Sex Male ☒ Female ☐

Home Address

Name and Address of Employer or Organization | Job Title

Telephone Number (Home) (Work) | Date Hired

Marital Status: ☒ Married ☐ Single ☐ Widowed ☐ Divorced

PAYMENT CHOICE
- ☒ 1199/1187 GOV'T PAYCHECK
- ☐ BANK AUTH PLAN
- ☐ ANNUAL PAYMENT

PLAN CHOICE
- ☐ 500 A
- ☐ 500 B
- ☐ 100 Money Saver
- ☒ Plan 1

Dental Center No. (If Applicable) _____

LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr.	Last Name (if different)	First Name	Initial	Sex M F	Birthdate Mo. Day Yr.
2. Spouse			F		5.			F	
3. Child			F		6.			F	
4.			F		7.			F	

Does Spouse have a dental plan? ☐ Yes ☒ No With whom? _____
If answer is "Yes" are dependents enroled under spouse's plan? ☐ Yes ☒ No

OFFICE USE ONLY | GROUP # | EFFECTIVE DATE

I UNDERSTAND THIS CONTRACT IS FOR A MINIMUM OF TWELVE MONTHS, AND RENEWED FOR TWELVE MONTHS PERIODS THEREAFTER. PLAN REQUIRES THIRTY DAYS WRITTEN NOTIFICATION OF INTENT TO CANCEL, AND IN THE EVENT OF SEPERATION OR TERMINATION, I AGREE TO PAY THE BALANCE OF ANNUAL PREMIUMS.

X _____ DATE _____

MEMBER'S SIGNATURE