

**HILLSBOROUGH
COUNTY GOVERNMENT
CONTRIBUTION RATES:
CS 150 HIGH - OPTION**

	MONTHLY	ANNUALLY
	Pre-Authorized Bank Draft	Visa/Mastercard Check or M.O.
Retiree.....	\$13.52	\$162.24
Retiree +1 Dependent.....	\$25.27	\$303.24
Retiree + Family.....	\$32.86	\$394.32

MONTHLY BANK DRAFT:

	MONTHLY	ANNUALLY
	Pre-Authorized Bank Draft	Visa/Mastercard Check or M.O.
Administrative Fee	\$1.00	.00

ACT NOW.

Simply complete and mail the attached application.
This is your first step to maintaining good oral health
with CompBenefits.



ENROLLMENT INSTRUCTIONS:

- Complete the application. (Be sure to list all Family Members to be included.)
- Each family member selects a dental office from the Provider List and indicate the dental facility number on the application.
- Select your payment mode.
 - If MONTHLY, complete the authorization for deduction with full bank information and sign in the lower portion. (Be sure to enclose first month's premium and a blank voided check.)
 - If ANNUAL, choose Visa or MasterCard. Fill out bank card section and send no money, or enclose your check for the full annual premium.
- Make check payable to CompBenefits. Completed applications, with correct premiums, received by Home Office by the 15th of the month will become effective on the 1st of the following month.
CompBenefits P.O. Box 769649, Roswell GA 33076-8225

Social Security No.	Last Name	First	MI	Date of Birth / /		
Home Address		Area Code	Home Phone	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
City	State	Zip Code	Area Code	Business Phone Dental Facility #		
List All Your Eligible Dependents If They Are To Be Covered						
	Dental Facility #	First	Middle	Last (if Different)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate / /
2. Spouse:						
3. Child:						
4. Child:						
5. Child:						
Coverage Effective Date						
# Dependents Covered	Plan Code	Annual CS150-D41 Bank Draft CS150-970	Premium Amount \$	Amount Paid \$	Agent Code	
This Membership Agreement Is Not Effective Until You Receive Your Certificate of Benefits.						

I wish to enroll in the CompBenefits plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided as described in the description of benefits and surcharges. I have received and understand the outline of coverage.

Applicant's Signature: x _____ Agent's Signature: _____

- FOLD HERE AND STAPLE - If A Check or Money Order is Enclosed, Staple Through All Parts.

AUTHORIZATION FOR DEDUCTION - Signature Required

Name: _____ Social Security No. _____
(Last) (First) (MI)

I authorize: _____
(Financial Institution)

To make a Monthly Bank Draft (include \$1.00 monthly administrative fee)

Deductions of \$ _____ From: _____ Drafted on the 15th

My Checking Account # _____ (Monthly Only)

and to remit the amounts deducted to CompBenefits (CB), upon instructions from CB. The amount of deduction indicated above is approximate and may be corrected as instructed by CB. This authorization shall cease (a) upon my giving written cancellation notice to you; (b) automatically upon my termination as an employee, member or depositor, as the case may be, of the above-named organization; (c) automatically upon termination of my checking, savings or share account number above as this authorization relates to such an account; or (d) upon discontinuance of the deduction and remittance arrangements between the above-named organization and CB. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by CB, and if this authorization terminates for any reason, any further payments required under said policy(ies) shall be made as provided in the policy(ies). I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent of CB.

Date Signed: _____ 20 _____ Signature X _____

BANK CARD SELECTION

For Your Convenience:

Expiration Date MasterCard Visa
MO. YR.

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FILL IN CARD NUMBER

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AMOUNT

CHARGED ANNUAL CONTRIBUTION \$ _____

I hereby authorize charging my Bank Card.

CARDHOLDER'S
SIGNATURE X _____

DATE _____

TO: THE EMPLOYER, FINANCIAL, OR OTHER ORGANIZATION NAMED ON THE REVERSE SIDE.

In consideration of your paying checks and drafts drawn or purported to be drawn by the undersigned on the checking account of any of your depositors, undersigned hereby agrees that:

- (1) I will indemnify you against and hold you harmless from any and all liability, loss, damage and expense which may be incurred by you because of your payment or dishonor of any such checks so drawn or purported to be drawn whether the payment or dishonor was intentional or through inadvertence, and will further indemnify and hold you harmless from any liability to any persons making claims under any Agreement with respect to which checks are drawn. We will refund you any amount erroneously paid by you on any such check;
- (2) It will refund to you any amount erroneously paid by you to undersigned on any such check if claim is made therefore by you within 3 months from the date of payment; and
- (3) Either you or undersigned may terminate this agreement by ten (10) days prior written notice by either to the other or the agreement will be immediately terminated on the closing of the depositor's account or by the revocation by the depositor of authorization, but any such termination shall not affect undersigned's obligations and liabilities hereunder with respect to any such checks or dishonored by you prior to termination.



CompBenefits Company

President: _____

Signature

HOME OFFICE USE
TRANSIT NUMBER _____ C.U. NBR. _____
ACCOUNT NUMBER _____
DATE DRAFT 15 _____
BUYER'S NAME _____