# PPO ENROLLMENT FORM

## Insured by CompDent Insurance Company, Roswell, Georgia

**ENROLLMENT INSTRUCTIONS:**

1. Complete the enrollment form. (Be sure to list all Family Members to be included)
2. Complete the authorization for deduction with full information and sign in the lower portion.
3. Return the completed enrollment form and authorization for deduction to your payroll department for processing.

| SOCIAL SECURITY # | LAST NAME | FIRST | MI | DATE OF BIRTH / / |
|---|---|---|---|---|
| HOME ADDRESS | | AREA CODE | HOME PHONE | SEX ☐M ☐F |
| CITY | STATE | ZIP CODE | AREA CODE / BUSINESS PHONE | EMAIL ADDRESS |
| NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION | | OCCUPATION (TITLE) | | DATE HIRED FULL TIME |

**LIST ALL YOUR ELIGIBLE DEPENDENTS, IF THEY ARE TO BE COVERED**

| FIRST M.I. LAST | SOCIAL SECURITY # | SEX | BIRTHDATE |
|---|---|---|---|
| SPOUSE: | | ☐M ☐F | / / |
| CHILD: | | ☐M ☐F | / / |
| CHILD: | | ☐M ☐F | / / |
| CHILD: | | ☐M ☐F | / / |

| EFFECTIVE DATE | PLAN CODE | GROUP CODE # | PREMIUM AMOUNT $ | AMOUNT PAID $ | AGENT CODE |
|---|---|---|---|---|---|
| | | | | | |

I hereby consent, personally and on behalf of any family members enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompDent for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.Futhermore, I acknowledge that I have been informed of the following: 1) the number, mix and distribution of participating providers; 2) the existance of limitations on choices of health care providers; and 3) a summary of any agreements between the plan and the provider as they pertain to financial incentives or disincentives, if any.

**Member's Signature:** _____ **Date:** _____

**Agent's Signature:** _____

**Please Note:**
Any person who, with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Completed applications, with correct premiums, received by the Home Office by the 15th of the month will become effective on the 1st of the following month.

**AUTHORIZATION FOR DEDUCTION** – Signature Required – Employer

Name: _____ Social Security #: _____

I authorize _____ To make a: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
(Employer, Financial, or other organization) Check correct payment method

Deductions of $ _____ From: My salary or other compensation,

and to remit the amount deducted to **CompDent (CD)**, upon instruction from **CD**. The amount of deduction indicated above is approximate and may be corrected as instructed by **CD**. This authorization shall cease (a) upon my giving written cancellation notice to you; or (b) automatically upon my termination as a member or depositor, as the case may be, of the above named organization. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CD** 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 for **CD**.

Applicants Signature: _____ Date Signed: _____

**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 herby agrees that:

(1) It 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 claim 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 (12) 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 labilities hereunder with respect to any such checks or dishonored by your prior to termination.

**CompDent**

*Secretary* _____

*Signature*

*The above is a true and correct resolution passed by the Board of Directors of CompDent Corporation*

# Our Goal . . .

**. . . is to restore you and your family to good oral health and keep you that way for the rest of your lives.**