HILLSBOROUGH COUNTY GOVERNMENT CONTRIBUTION RATES: HS 195 HIGH - OPTION

	MONTHLY Pre-Authorized Bank Draft	ANNUALLY Visa/Mastercard Check or M.O.
Retiree	$15.40	$184.80
Retiree +1 Dependent	$28.80	$345.60
Retiree + Family	$37.44	$449.28

MONTHLY BANK DRAFT:

	MONTHLY Pre-Authorized Bank Draft	ANNUALLY 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.

Humana®

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. Each family member selects a dental office from the Provider List and indicate the dental facility number on the application.
3. Select your payment mode.
   a. 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.)
   b. If ANNUAL, choose Visa or MasterCard. Fill out bank card section and send no money, or enclose your check for the full annual premium.
4. 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 Dental Vision
P.O. Box 769649, Roswell, GA 30076-82257.44

Social Security No.	Last Name	First	MI	Date of Birth / /
Home Address		Area Code	Home Phone	Sex ☐ M ☐ F
City	State / Zip Code	Area Code	Business Phone	Dental Facility #

List All Your Eligible Dependents If They Are To Be Covered

		First	Middle	Last (if Different)	SEX	Birthdate
2. Spouse:	Dental Facility #				☐M ☐F	/ /
3. Child:	Dental Facility #				☐M ☐F	/ /
4. Child:	Dental Facility #				☐M ☐F	/ /
5. Child:	Dental Facility #				☐M ☐F	/ /

Coverage Effective Date				
# Dependents Covered	Plan Code: Annual HS195I-3 / Bank Draft HS195I-4	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 my 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** _____

062000B 9/02

BANK CARD SELECTION

For Your Convenience:

Expiration Date MO. YR. ☐MasterCard ☐Visa

FILL IN CARD NUMBER

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 nadvertence, 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. W e 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 my 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 _____