☐ PREPAID – CHOICE ONE

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (Be sure to list all Family Members to be included.)
2. **Select a dental office from the Provider List and Insert the dental facility number on the application.**
3. Complete the authorization for deduction with full information and sign in the lower portion.
4. Return the completed application and authorization for deduction to your payroll department for processing. Deductions from your account will be made in accordance with the procedures established and communicated by your employer.

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.

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	DENTAL FACILITY #

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION	EMPLOYER'S GROUP ADMINISTRATOR
Texas Police Benefit Trust	

PREFERRED LANGUAGE (IF NOT ENGLISH):

INDICATE ANY SPECIAL NEEDS (PLEASE CIRCLE): Braille, Audio Tape, Large Print, Interpreter, TDYY, Other:

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

(Eligible dependents include your spouse and/or unmarried children from birth to age 19 or to age 23 if a child is both a full-time sutdent and dependent on you for primary support.)

	FIRST	MIDDLE	LAST (if different)	ALT. DENTAL FACILITY #	SEX	BIRTHDATE
2. SPOUSE:					☐M ☐F	/ /
3. CHILD:					☐M ☐F	/ /
4. CHILD:					☐M ☐F	/ /
5. CHILD:					☐M ☐F	/ /
COVERAGE EFFECTIVE DATE						

# DEPENDENTS COVERED	PLAN CODE	CD GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE
			$	$	

THIS MEMBERSHIP AGREEMENT IS NOT EFFECTIVE UNTIL YOU RECIEVE YOUR AGREEMENT AND CERTIFICATE OF BENEFITS.

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

Applicant's Signature: _____ **Date:** _____

Agent's Signature: _____

☐ PPO - CHOICE TWO

ENROLLMENT INSTRUCTIONS:

1. Complete the application. (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 application and authorization for deduction to your payroll department for processing. Deductions from your payroll will be made in accordance with the procedures established and communicated by your employer.

Please Note:
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
You may cancel either contract within 30 days of enrollment date.

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

NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION	OCCUPATION (TITLE)	DATE HIRED FULL TIME
Texas Police Benefit Trust		

PREFERRED LANGUAGE (IF NOT ENGLISH):

INDICATE ANY SPECIAL NEEDS (PLEASE CIRCLE): Braille, Audio Tape, Large Print, Interpreter, TDYY, Other:

LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED

(Eligible dependents include your spouse and/or unmarried children from birth to age 19 or to age 23 if a child is both a full-time sutdent and dependent on you for primary support.)

	FIRST	MIDDLE	LAST (if different)	SEX	BIRTHDATE
SPOUSE:				☐M ☐F	/ /
CHILD:				☐M ☐F	/ /
CHILD:				☐M ☐F	/ /
CHILD:				☐M ☐F	/ /
BENEFICIARY NAME AND RELATIONSHIP (i.e., Mary Jones, Wife)					# DEPENDENTS COVERED

COVERAGE EFFECTIVE DATE	PLAN CODE	CD GROUP CODE #	PREMIUM AMOUNT	AMOUNT PAID	AGENT CODE
			$	$	

THIS MEMBERSHIP AGREEMENT IS NOT EFFECTIVE UNTIL YOU RECIEVE YOUR AGREEMENT AND CERTIFICATE OF BENEFITS.

I hereby (1) request coverage for the Group Dental coverage for which I am or may become eligible, (2) authorize my employer to make the necessary deductions for contributions, if any, required for the insurance, or agree that the contributions be added to my dues, and (3) designate the beneficiary named on this card to receive the proceeds, if any, payable in the event of my death.

Applicant's Signature: _____ **Date:** _____

Agent's Signature: _____

CompBenefits
The dental and vision benefits company of choice!

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) 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 person 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 any 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 obligation and liabilities hereunder with respect to any such checks or dishonored by you prior to termination.

CompBenefits

Secretary: R a m s t a n

The above is a true and correct resolution pased by the Board of Directors of CompBenefits, Inc.

AUTHORIZATION FOR DEDUCTION – Signature Required – Employer

Name _____ Social Security No. _____

I authorize _____

(Employer, Financial, or other organization)

To make a ☐Weekly ☐Bi-Weekly ☐Semi-Monthly ☐Monthly (Check correct payment method)

Deductions of $ _____ From:

☐My Salary or Other Compensation
☐My Association or Other Organization Account

and to remit the amount deducted to **CompBenefits (CB)** Atlanta, Georgia, 30076, 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 a member or depositor, as the case may be, of the above named organization; (c) automatically upon termination of my checking or savings account number above as this authorization related 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 proved 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 **CB.**

Date Signed _____ Signature _____