

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: New Dental Choice

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



Enroll today by completing the form below. To expedite your enrollment go online to NewDentalChoice.com or call (866) 710-7645

NAME		DATE OF BIRTH	SEX	HOME PHONE
<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="radio"/> M <input type="radio"/> F	(<input type="text"/>) <input type="text"/>
ADDRESS (Mailing)	Apt/Unit#	CITY/STATE	ZIP	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
EMAIL		ALTERNATE or MOBILE PHONE		
<input type="text"/>		(<input type="text"/>) <input type="text"/>		
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SEX	
<input type="text"/>	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="radio"/> M <input type="radio"/> F	
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SEX	
<input type="text"/>	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="radio"/> M <input type="radio"/> F	
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SEX	
<input type="text"/>	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="radio"/> M <input type="radio"/> F	
EMPLOYER NAME	REFERRAL SOURCE / AGENT NAME			
<input type="text"/>	<input type="text"/>			

PLAN PAYMENT OPTIONS

DENTAL ONLY | 

Please select a plan and payment option:

INDIVIDUAL PLAN

- Pay Yearly \$96 + \$10 activation fee*
- Pay Monthly \$8 + \$25 activation fee* (Credit Card ONLY)

FAMILY PLAN

- Pay Yearly \$120 + \$10 activation fee*
- Pay Monthly \$10 + \$25 activation fee* (Credit Card ONLY)

* The activation fee is a one-time fee and is non-refundable

DENTAL + ADD-ONS |    

Please select a plan and payment option:

INDIVIDUAL PLAN

- Pay Yearly \$115.00 + \$10 activation fee*
- Pay Monthly \$10.95 + \$25 activation fee* (Credit Card ONLY)

FAMILY PLAN

- Pay Yearly \$139.00 + \$10 activation fee*
- Pay Monthly \$12.95 + \$25 activation fee* (Credit Card ONLY)

* The activation fee is a one-time fee and is non-refundable

METHOD OF PAYMENT

CHOOSE FROM OPTION A OR B

A BILL MY CREDIT CARD (CHECK ONE) VISA MASTERCARD AMERICAN EXPRESS

I agree that you will bill my credit card account to automatically renew my membership each year.

NAME ON CREDIT CARD	ACCOUNT NUMBER	EXPIRATION
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>
CREDIT CARD BILLING ADDRESS <input type="checkbox"/> SAME BILLING INFORMATION AS SUBSCRIBER		
<input type="text"/>		

B CHECK IS ENCLOSED FOR THE YEARLY RATE + ACTIVATION FEE

CHECK PAYABLE TO: NEW DENTAL CHOICE SEND TO: P.O. BOX 919029 SAN DIEGO, CA 92191

SIGNATURE AUTHORIZATION REQUIRED

I understand the Plan Description of Services and Membership Agreement¹ and understand I may cancel my membership within 30 days and receive a full refund (less the activation fee)².

SIGNATURE

¹Prior to enrollment New Dental Choice is required to provide the "Plan Description of Services and Membership Agreement."
²To receive this information visit newdentalchoice.com or call (888) 632-5563. ²Refunds vary by state.

Easy to Understand Fine Print.

New Dental Choice is not insurance - it is a Specialized Health Service Plan provided by First Dental Health. This plan offers discounts on multiple specialized health services to members and the fees vary by region and type of service received. First Dental Health solely arranges for access to discounts from independent third party service providers, does not warrant or guarantee the suitability and/or quality of any service provided and is not the provider of services under this program.

Dental Specialists may not be available in all areas. A member's participation in this program is governed by the terms of the "Plan Description and Disclosure Form." Services in progress or provided before the effective date of the member's enrollment in New Dental Choice are excluded. The plan effective date is the date the plan member receives their ID card.