HEALTHPLEX.
THE DENTAL BENEFIT EXPERTS™

Dental Plan Enrollment Form

FOR DENTAL PLANS BY DENTCARE DELIVERY SYSTEMS, INC., INTERNATIONAL HEALTHCARE SERVICES, INC., HEALTHPLEX INSURANCE COMPANY, OR HEALTHPLEX, INC.

Employee Information

Last Name	First Name	M.I.	SSN/ID Number

Address	City	State	Zip Code

Home Phone	Work Phone	Gender	D.O.B.

Employer Name/Group	Group Number	Effective Date	Date of Hire
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Other Dental Coverage: ☐ NO ☐ YES	Name of Other Plan (if applicable):

Group Plan Selection

- ☒ CapDent New York
- ☐ CapDent Plus New York
- ☐ CapDent Plus Ultra
- ☐ Preferred Choice Plan
- ☐ Omni PPO
- ☐ Comprehensive Voluntary
- ☐ Low Option
- ☐ Medium Option
- ☐ High Option
- ☐ High Enhanced Option
- ☐ CapDent New Jersey
- ☐ CapDent Plus New Jersey
- ☐ Primary ☐ EPO
- ☐ CapDent Select
- ☐ CapDent Select Plus
- ☐ Healthplex Insurance Company Plan

Coverage Selected

☐ Single ☐ Two Party ☐ Family

Dental Selection

Dentist Name	Dentist Site Code

For Managed Care Plans - Please choose one Primary Care Dentist from the CapDent Directory - One Per Family

Dependents To Be Covered (Spouse, Domestic Partner & unmarried dependent children) * If your child is over the age of 18, you must submit student documentation.

Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
*Last Name, First Name					
*Last Name, First Name					

***There is an additional monthly premium of $10.00 for each family member in excess of five (5).**

Signature	Date

Broker Information

Broker Name	SSN/Tax ID #

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

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"PLEASE PRINT OR TYPE ALL INFORMATION"