

Assurant Employee Benefits Application Form

Please retain a copy of this application for your records

AGENT NUMBER

4D00516-1

Your Social Security Number	Last Name	First Name	Middle I.	Sex M <input type="checkbox"/>	IMPORTANT Write the Dental Facility Number of the dentist(s) you choose from the directory in the space(s) below.
				F <input type="checkbox"/>	
Your Date of Birth / /	Address				
Home Phone ()	City	State	Zip Code+4		

List Dependents to be Enrolled						Dental Facility Number
First Name	Middle I.	Last Name (if different)	Relationship	Date of Birth	Sex	
Spouse				/ /	M <input type="checkbox"/> F <input type="checkbox"/>	
Child				/ /	M <input type="checkbox"/> F <input type="checkbox"/>	
Child				/ /	M <input type="checkbox"/> F <input type="checkbox"/>	

Attach a separate sheet of paper for additional children.

Prepayment Fee Amount \$ _____ +Enrollment Fee \$35.00 Total Enclosed \$ _____	<input type="checkbox"/> Annual Payment - make the check payable to Fortis Benefits Insurance Company. <input type="checkbox"/> Charge my annual prepayment fees <input type="checkbox"/> Automatic Monthly Bank Draft - complete the Authorization Agreement on the reverse side of this form.	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover Exp. Date Mo. ____ Yr. ____
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By my signature below, I understand that this Individual Prepaid Dental Plan is a non-refundable one (1) year program. I also understand that a full description of the plan will be provided in the Individual Dental Service Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to Fortis Benefits Insurance Company my dental records, photocopies or information regarding such procedures to the extent permitted by law. Any person who knowingly and 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. This authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Fortis Benefits Insurance Company and its affiliated dental companies to use and disclose protected health information.

Agent's Signature _____ Date _____ Subscriber's Signature _____ Date _____

10.40 16.74 25.68
 109.82 185.86 293.15
 BDC-IAPP-FL

This is an important document that will become part of your contract. Benefits administered by Fortis Benefits Insurance Company and provided by DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes.