

SELECT DENTALADVANTAGE

INDIVIDUAL / FAMILY APPLICATION FORM FOR A DISCOUNT DENTAL PLAN

Please complete this membership application and return via fax to (877) 329-7246, or mail to SELECT BENEFITS, Attn: Select Dental Advantage, 105 Walnut Street, Lawrenceburg, IN 47025.

STEP ONE: CONTACT INFORMATION - Please Print Clearly

Question? Call 800-613-4841

LAST NAME		FIRST NAME	
ADDRESS		CITY, STATE, ZIP	
HOME PHONE	WORK PHONE	EMAIL ADDRESS	
SPOUSE'S NAME (IF INCLUDED)			
OTHER HOUSEHOLD MEMBERS (IF INCLUDED)			
1.	3.		
2.	4.		

Note: To make changes or additions to your plan, please contact Member Services at 888-636-2378

STEP TWO: CHECK PLAN TYPE & BILLING

<input type="checkbox"/> Select DENTALADVANTAGE <i>(INDIVIDUAL & FAMILY COVERAGE)</i>		
SELECT DENTAL ADVANTAGE	<u>MONTHLY</u> \$6.00	<u>ANNUAL</u> \$66.00

****A one time non-refundable processing fee of \$15.00 applies to all membership plans***

STEP TWO: CHECK PLAN TYPE & BILLING Payment Options: Please circle one

Credit Card: Monthly or Annual [\$21.00 1st month then \$6.00 a month/ or \$81.00 annual] I, _____, hereby authorize SBGMC (Select Benefits) to charge my credit card for Services rendered as described above.

Payment Terms (for Credit Card Enrollment Only): Monthly Annual
 Credit Card---Check one: Visa Mastercard American Express

Card Number: _____ - _____ - _____ - _____ Exp Date: ____/____

Name as it Appears on card _____

Signature _____ *Date* ____/____/____

- Money Order*(Annual Enrollment ONLY) [\$81.00 annual]**
- Personal Check*(Annual Enrollment ONLY) [\$81.00 annual]**

***Please make all Checks or Money Orders payable to: SELECT BENEFITS**

