Momentum
DENTAL PLANS

Individual Dental Plan Enrollment Form

Momentum Insurance Plans, Inc.
2971 Chapel Valley Road
Madison, WI 53711
608.729.6500
momentumplans.com

PLAN OPTIONS

Requested Effective Date (must be the 1st of an upcoming month): _____/_____/_____

☐ **Protect Plan:**
√ DHA Network

☐ **Gold Plan (check one):**
☐ DHA Network
☐ Commercial Network

☐ **Platinum Plan (check one):**
☐ DHA Network
☐ Commercial Network

COVERAGE TYPE

☐ Single ☐ Couple ☐ Family ☐ Limited Family (1 adult + 1 child) ☐ Child/Children Only _____# of children

MEMBER INFORMATION

Last Name _____ First Name _____ MI _____

Social Security # _____ ☐ Male ☐ Female

Home Address _____

City _____ State _____ Zip _____

_____-_____-_____ ☐ Home Phone ☐ Cell Phone Work Phone _____-_____-_____

Marital Status _____ Date of Birth _____/_____/_____

Email _____

DEPENDENT INFORMATION *List all eligible family members to be covered*

1. Spouse Last Name _____ First Name _____ MI _____

☐ Male ☐ Female Date of Birth _____/_____/_____ Dependent Relationship (spouse, son, daughter) _____

2. Dependent Last Name _____ First Name _____ MI _____

☐ Male ☐ Female Date of Birth _____/_____/_____ Dependent Relationship (spouse, son, daughter) _____

3. Dependent Last Name _____ First Name _____ MI _____

☐ Male ☐ Female Date of Birth _____/_____/_____ Dependent Relationship (spouse, son, daughter) _____

4. Dependent Last Name _____ First Name _____ MI _____

☐ Male ☐ Female Date of Birth _____/_____/_____ Dependent Relationship (spouse, son, daughter) _____

COORDINATION OF BENEFITS

Are you, your spouse, or other dependent(s) covered by any other dental plan that will remain in effect? ☐ Yes ☐ No

If yes, which family member(s) will be covered? ☐ Self ☐ Spouse ☐ Dependent(s)

Please list all other dental coverage below:

1. Name of Person(s) Insured _____ Name of Person Policy is Issued to _____

   Policy # _____ Name of Plan/Insurance Company _____

   Address _____

2. Name of Person(s) Insured _____ Name of Person Policy is Issued to _____

   Policy # _____ Name of Plan/Insurance Company _____

   Address _____

PRIOR COVERAGE

Has applicant had previous dental coverage? ☐ Yes ☐ No

1. Name of Person Insured _____

   Policy # _____ Name of Previous Plan/Insurance Company_____

   Coverage Started On _____/_____/_____ Coverage Ended On _____/_____/_____

2. Name of Person Insured _____

   Policy # _____ Name of Previous Plan/Insurance Company_____

   Coverage Started On _____/_____/_____ Coverage Ended On _____/_____/_____

ACCEPTANCE

I accept the Individual Plan coverage provided by Momentum Insurance Plans, Inc. I understand that by accepting insurance coverage, I am required to remit premiums according to the method of payment selected below on or before the 20th day of the month preceding the month of coverage for which payment is being made. Addition or deletion of dependents, and any other changes to coverage are allowed only based on a qualifying event as described in the Individual Plan policy. Coverage will be effective only upon acceptance and approval by Momentum Insurance Plans, Inc.

By signing this form, I certify that all information supplied is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the terms of the plan(s) in which I have enrolled and I agree to abide by the terms and conditions provided in the plan(s).

Applicant Signature_____ Date _____

METHOD OF PAYMENT AND AUTHORIZATION *Select one of the following options:*

1. ☐ By my signature below, I authorize Momentum Insurance Plans, Inc. to initiate a debit entry to the account and institution indicated below. ***My check for the initial 3 month period of coverage will be submitted with this application.*** Each month thereafter, debits will be made on the 20th day of the month, prior to the coverage month, for each monthly payment.

   Name of Financial Institution _____

   Bank Routing Number_____ Account Number _____

   Please select account type and include a copy of the voided check or deposit slip ☐ Checking ☐ Savings

2. ☐ By my signature below, I authorize Momentum Insurance Plans, Inc. ***to initiate a debit entry to the credit card account (Discover, MasterCard, Visa) indicated below in the amount of 3 months premium for the initial payment.*** Each month thereafter, debits will be made on the 20th day of the month, prior to the coverage month, for each monthly payment.

   Credit Card Number _____-_____-_____-_____ Expiration Date _____/_____

This authority is to remain in full force and effective until Momentum Insurance Plans, Inc. and said financial institution have received written notification from me of its termination in such time and manner as to afford Momentum Insurance Plans, Inc. and said financial institution reasonable opportunity to act upon it.

Applicant Signature_____ Date _____

AGENT INFORMATION

Agency Name _____ Agent Name _____

Agent # _____ Agent Signature _____ Date _____