



Individual Product
Enrollment Information

Complete the individual Enrollment application.

If you have current group dental coverage we will need proof of coverage from the group carrier including information on covered benefits, when coverage was effective, and when coverage terminated, if you would like Momentum to consider waiving policy waiting periods.

If you have prior individual coverage we will require proof of coverage from your individual policy carrier including information on covered benefits, when coverage was effective, and when coverage terminated, if you would like Momentum to consider waiving policy waiting periods.

If you choose the ACH payment option, we will require a check for the initial 3 month period of coverage along with the application. After that initial period we will then automatically debit your account on the 20th of the month prior to the month of coverage starting with the 4th month of coverage.

If you choose the credit card payment option, we will initiate a debit entry for the initial 3 month period, and then monthly on the 20th of the month prior to the month of coverage starting with the 4th month of coverage.

Do Not cancel any existing dental coverage until Momentum Insurance Plans, Inc. has approved your coverage.

Submit your application, Initial 3 month's premium or credit card information, and documentation to:

Momentum Insurance Plans, Inc.
Individual Plan Enrollment
2971 Chapel Valley Road
Madison, WI 53711



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 _____