

# United Dental Care of Arizona, Inc. Application Form

Please retain a copy of this application for your records

AGENT NUMBER

Your Social Security Number	Last Name	First Name	Middle I.	Sex M <input type="checkbox"/>	<b>IMPORTANT</b> 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.						

<b>Prepayment Fee Amount</b> \$ _____ <b>+Enrollment Fee</b> \$ <b>35.00</b> <b>Total Enclosed \$</b> _____	<b>Select Payment Choice</b> <input type="checkbox"/> <b>Annual Payment</b> - make the check payable to Union Security Insurance Company. <input type="checkbox"/> <b>Charge my annual prepayment fees</b> <input type="checkbox"/> <b>Automatic Monthly Bank Draft</b> - 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. _____ <table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>																		

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 Union Security Insurance Company and its affiliated dental companies my dental records, photocopies or information regarding such procedures to the extent permitted by law. It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of benefits. This authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company and its affiliated dental companies to use and disclose protected health information.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

12.24 19.84 30.57  
131.82 223.08 351.86  
BDC-IAPP-AZ

This is an important document that will become part of your contract. Benefits administered by Union Security Insurance Company and provided by United Dental Care of Arizona, Inc.

