MANATEE
SMILE CARE PLAN

Dental Plan Enrollment Form

Phone: 941-792-7777 www.manateeadvanceddentistry.com

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

Last Name	**First Name**	
Street Address		
City	**State**	**Zip Code**
Phone ☐ Cell ☐ Home / Text OK? ☐ Yes ☐ No	**Date of Birth** (MM/DD/YYYY)	
SSN	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female
Email		
Employer's Name & Phone Number		
Covered by other DENTAL Insurance? ☐ Yes ☐ No		
Total Premium Due $ ______________________		

List all dependents to be covered

Spouse Name - (Last, First, MI)	☐ **Plan A:** Child Care Plan ($179 / year) ☐ **Plan B:** Adult Care Plan ($249 / year) ☐ **Plan C:** Gum Care Plan ($399 / year)
Dependent Name - (Last, First, MI)	☐ **Plan A:** Child Care Plan ($179 / year) ☐ **Plan B:** Adult Care Plan ($249 / year) ☐ **Plan C:** Gum Care Plan ($399 / year)
Dependent Name - (Last, First, MI)	☐ **Plan A:** Child Care Plan ($179 / year) ☐ **Plan B:** Adult Care Plan ($249 / year) ☐ **Plan C:** Gum Care Plan ($399 / year)
Dependent Name - (Last, First, MI)	☐ **Plan A:** Child Care Plan ($179 / year) ☐ **Plan B:** Adult Care Plan ($249 / year) ☐ **Plan C:** Gum Care Plan ($399 / year)

For additional dependents attach an additional sheet

Renewal Date:- ___ ___ / ___ ___ ___ ___
Total Premium:- $ ___ ___ ___ ___ . ___ ___

Choose Your Plan Type *(Choose only one Plan choices may vary per state.)*

☐ **Plan A:** Child Care Plan ($179 / year)
☐ **Plan B:** Adult Care Plan ($249 / year)
☐ **Plan C:** Gum Care Plan ($399 / year)

Current Insurance Plan *(if any)*

Who is responsible for the account

Relationship to patient:

Insurance Co:

Group #:

Is pateint covered by addtional insurance?:

Subscriber's Name:

Birthdate:

Relationship to Patient:

Insurance Co:

Group #:

i hereby understand that my enrollment and benefits utillization in manatee smile care plan will be initiated after my exisitng insurance maximum benefits are used to their annual maximum or for procedures which are not covered by my exisitng insurance.

Payment Options *(Choose either Checking/Savings or Credit Card Payment)*

Billing Period: ☐ Annual *(Check or Credit Card)*

Checking or Savings

☐ *Checking Account* *(Include Voided Check)* ☐ *Savings Account* *(Include Deposit Slip)*

Financial Institution:

Routing Number:

Account Number:

Credit Card Payment *(Include your check for the $15.00 enrollment fee)*

☐ **VISA** ☐ **MASTERCARD** ☐ **AMERICAN EXPRESS** ☐ **DISCOVER**

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ *Exp. Date:* ☐☐/☐☐

Account Holder Name:

______________________________ ______________
Account Holder Signature: *Date:*

I wish to enroll in the plan I have selected. I authorize and agree to account deduction of the required premium.

This authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution at least seven business days before next renewal date written above. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. Please direct billing inquiries to Manatee Advanced Dentistry, 507 50th street, West Bradenton, Florida 34209. I have read and understand the statements above pertaining to the billing option. I understand that this is a 12 month agreement with OPTION to renew at the end of 12 month term. An early termination will result in a penalty upto remaining premium balance.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT

In the event there are insufficient funds when a draft is charged to my account, I agree to pay $25 NSF Fee. Manatee Advanced Dentistry reserves the right to deny me the ability to be reinstated on any personal MANATEE A SMILE CARE PLAN for two years.

______________________________ ______________
Signature: Date:

Please fill out and return this enrollment form with your payment to:

AH-10740 Manatee Advanced Dentistry, 507 50th street, West Bradenton, Florida 34209 Phone: 941-792-7777 Fax: 941-792-8400 Web: www.manateeadvanceddentistry.com