

TDAHP INDIVIDUAL DENTAL PLAN APPLICATION

Thank you for choosing Total Dental Administrators Health Plan (TDAHP) of Arizona

- § Please complete the entire application.
- § Be sure to select your primary dentist from the directory at www.totaldentaladmin.com. Write his/her 5-digit ID# in the space provided on the application. If you have any questions about choosing your dentist or need help completing this application, please call your broker or TDAHP at (602) 954-5602 or toll free at 1-866-954-5602.
Please Note: One Primary Dentist per contract (contract includes all applicants).
- § You may change dentists in the future if you notify the Plan, by the 25th day of the month. The change will be effective the 1st of the following month.
- § Be sure to attach a check or money order for the annual or monthly premium listed below. Applications received without payment are returned to the sender.
- § Monthly payments available when using Electronic Fund Transfer.
- § The effective date of your Dental Plan coverage will be the 1st day of the month following enrollment. Authorization for either monthly payment (EFT only) or annual Credit Card Payment must be received by TDAHP prior to the 20th day of the month.
- § Payment information – check, money order, cashiers check, or credit card accepted for annual payments.

<u>A800 Plan - Premium</u>	<u>Monthly</u>	<u>Annually</u>	<u>A1000 Plan – Premium</u>	<u>Monthly</u>	<u>Annually</u>
___ Individual	\$ 15.50	\$ 186.00	___ Individual	\$ 21.50	\$ 258.00
___ Individual + 1	\$ 27.50	\$ 330.00	___ Individual + 1	\$ 46.00	\$ 552.00
___ Individual + 2 or More	\$ 41.00	\$ 492.00	___ Individual + 2 or More	\$ 76.00	\$ 912.00

ELECTRONIC FUND TRANSFER

A convenient and affordable method of paying dental premiums. Instead of one annual premium, we can deduct monthly premiums from your bank account through a quick, no hassle, electronic fund transfer.

Please complete the sections below in bold. Payments are deducted from your account on or about the 15th of each month.
Please enclose a check for your 1st month's premium which will initiate the set-up of your electronic fund transfer.

Mail Your Completed Application and Payment to:
Total Dental Administrators Health Plan, Inc.
 2111 E. Highland Avenue, Suite 425
 Phoenix, AZ 85016

<u>CREDIT CARD PAYMENT (Annually Only)</u>	
Name _____	SS# _____
Amount _____	Visa <input type="radio"/> Mastercard <input type="radio"/>
Card # _____	Expiration Date _____ CVC 3 Number _____
Name on Card _____	Today's Date _____

<u>DIRECT PAYMENT AUTHORIZATION FORM (Monthly Only)</u>			
I (we) authorize TDAHP to initiate entries to debit my (our) account. (Please attached voided check)			
This authority is to remain in full force and effect until TDAHP has received written notification from me of its termination in such time and in such manner as to afford TDAHP a reasonable opportunity to act on it.			
Signature _____	Signature (Optional for Joint Account) _____		
Full Name _____	Full Name _____		
Date _____	Phone Number _____	Date _____	Phone Number _____