

PAYMENT AUTHORIZATION OUR PRE-AUTHORIZED PAYMENT PLAN

It's the forget-proof method of paying your premium. Just complete the appropriate authorization below and we'll do the rest. There will be no more paperwork, no more checks to write and no worries about coverage disruption. It's easy, secure and automatic.

AUTHORIZED AGREEMENT FOR PREARRANGED PAYMENTS (DEBITS)

DHMO Plan Enrollment

Direct Deposit/Bank Allotment (Payroll slot available for DHMO enrollment only. Administered by Dentalink, USA.)

Last Name: _____ **First Name:** _____ **MI:** _____

Payroll Center Address: _____

(Please verify with your local Payroll Office. Incorrect information can delay your effective date.)

DentaLink USA (COMPANY) is hereby authorized and requested by me to establish, on my behalf, an account with COMPANY'S BANK for receiving dental benefit premium/membership dues. I understand that this account will be used solely for the purpose of receiving monies by COMPANY for the payment of benefit premiums/membership dues for coverages/memberships arranged for me by COMPANY. I further understand that this account will be non-interest bearing. As an employee being paid through the above referenced payroll center, I acknowledge and understand that only I have the authority to initiate or to terminate allotments, from either my pay or my dues, to BANK and that any notice to initiate or to terminate an allotment, from my pay or from my dues, to BANK must be submitted by me and not by BANK or COMPANY to my employer, payroll center, or organization. I have authorized an allotment, from either my pay or my dues, to be paid to BANK for credit to my account. I hereby authorize and empower BANK to collect such funds and pay over such funds, as received, to COMPANY. This authority is to remain in full force and effect until BANK has received written notification from me of its termination. I understand I have the right to stop a transfer to COMPANY of funds received, on my behalf, by BANK by my written notification, to BANK, prior to the transfer of such funds. After written notification to Bank to cease transferring monies to COMPANY, I have the right to recover from BANK the amount of any erroneous transfer, to COMPANY, for up to 45 days from the time of the erroneous transfer. Additionally, I hereby authorize and empower COMPANY to receive and hold said allotted funds when paid over by BANK to COMPANY and to deduct COMPANY'S charge, to me, for coverages arranged for me. I also authorize and empower COMPANY to make premium/membership payments to the appropriate carriers for coverage that I have applied for. In applying for coverages arranged for me by COMPANY, I hereby agree to allot to BANK and have paid over to COMPANY no fewer than the minimum number of bi-weekly payments agreed to by me, on my separate-here-from application, for coverage underwritten by a specific carrier. I agree that COMPANY may decide, at any time, to change carriers and understand that Company will notify me of such change. If, in my opinion, the new carrier is not acceptable, I may terminate coverage by using the designated process. I understand that my allotting fewer than the minimum bi-weekly payments may result in my being billed by COMPANY for the remainder of the minimum payments agreed to. Also, I understand that COMPANY may charge me a fee of up to \$20.00 for any of the following: 1. An account history of debits/credits. Such requests must be in writing and accompanied by the required fee; 2. Reinstatement of coverage and acceptance of any arrearage premium/dues when allotments stop and coverage therefore has to be terminated; 3. Closing of this account when I do not notify Company, in writing, of my intention to terminate allotments hereto.

Signature: _____ **Date:** _____

PPO Plan Enrollment

Credit Card Number:
Credit Card Type: Visa MasterCard American Express Discover

Expiration Date: _____

Name as it appears on the card: _____

Pay By Bank Draft* (Checking account debit available for PPO enrollment only.)

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

*** Please attach a voided check to this form.**

TERMS: This authorization will remain in effect unless 30 days advance written notice of termination is received by Dominion Dental Services, Inc. or DentalLink, USA. In the event that any electronic debit or transfer is returned, I agree that a \$25.00 returned item fee will be automatically charged to my account.

AUTHORIZATION: I authorize Dominion Dental Services, Inc. to automatically deduct, on or about the 15th of each month, the following month's premium from the credit card OR bank account stated above.

Signature: _____ **Date:** _____

DHMO/PPO ENROLLMENT CARD & MONTHLY RATES

Rates valid for subscribers with effective dates of coverage beginning between November 1, 2006 and November 1, 2007. Subscribers' rates guaranteed for twelve (12) months following their effective date. Rates will be deducted on a monthly basis.

2007 Rates	Bi-Weekly DHMO Plan 603x	Bi-Weekly DHMO Plan 605x	Monthly ACCESSPlus PPO Plan
Employee	\$6.00	\$9.00	\$28.04
Employee & One	\$11.00	\$15.00	\$53.82
Family	\$16.00	\$23.00	\$75.11

I Choose: DHMO Plan 603x DHMO Plan 605x ACCESSPlus PPO Plan

Applicant Enrollment Information					
Last Name		First Name		M.I.	
Social Security Number		Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone	
Home Address			Work Phone		
City		State	Zip		
List All Your Eligible Dependents Below					
Last Name (if different)	First Name	M.I.	Sex	Birthdate	Soc. Sec. #
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					
DHMO Provider Selection		Dental Office Name & Code #			
Coverage Applied for: <input type="checkbox"/> Applicant Only <input type="checkbox"/> Applicant & One Dependent <input type="checkbox"/> Applicant & Two or More Dependents					
D	If I am voluntarily paying 100% of the cost of this Plan, without employer contribution, I agree to remain in the Plan a minimum of 12 months and/or be responsible for a minimum of twelve months of subscription dues. I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by dentists and other providers of dental services. Information will be released to Dominion Dental Services, Inc. for the purpose of quality assurance and/or utilization review. Authorization will be limited to the term of coverage of this policy. A copy of this form will be made available to the subscriber or their authorized representative upon request.				
H	Applicant's Signature _____ Date _____				
M	By my signature below, I hereby apply for PPO coverage under group dental insurance policy form GH-1112. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.				
O	Applicant's Signature _____ Date _____				
Code #	Group #	Group Name		Coverage Eff. Date	Plan #
001		AFGE			
Send to: DentalLink, USA, P.O. Box 12016, Newport News, VA 23612					