



DENTAL ENROLLMENT APPLICATION

A. PRIMARY APPLICANT INFORMATION *(Please Print)*

Check Type of Coverage: Individual Applicant plus One (1) Dependent Family

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS	STREET	CITY	STATE	ZIP
DATE OF BIRTH	TELEPHONE NUMBER ()	E-MAIL <i>(if available)</i>		

B. TYPE OF DENTAL PLAN: Plan 5000 Plan 5500 Plan 4500

C. DEPENDENT INFORMATION *(Please complete this section only if you are applying for dependent coverage.)*

Eligible dependent children must be between the ages of 4 and 26 and single. Dependents over 26 years and under 30 years old must provide verification of a copy of their honorable discharge from the U.S. Armed Forces approved by the Illinois Department of Veteran Affairs.

LAST NAME	FIRST NAME	RELATION (spouse or child)	SEX M or F	DATE OF BIRTH	DISCHARGED VETERAN
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

D. DENTAL CHOICE

List the selected dental center location number: _____ *(Please review the dental directory.)*

E. REQUESTED EFFECTIVE DATE OF COVERAGE (MM/DD/YY) _____

(All policies become effective on the 1st day of the following month.)

F. AGREEMENT:

I am applying for Dental coverage as indicated in Sections A, B and C (where applicable) for which I am or may become eligible under this agreement with Olympia Limited Health Services Organization. This agreement will be in force for one (1) year from its effective date of coverage and will automatically renew for successive one-year terms thereafter. This agreement can be terminated after one (1) year by providing Olympia with written thirty (30) day prior notification. Adjustments in premium rates can occur every year and changes in the discounted dental fee schedules can occur after each two-year renewal period for this agreement. **All benefits must be provided by a participating Network Dental provider.** I have read and understand the Outline of Coverage that has been provided to me by Olympia or by my agent. Olympia and/or my agent has informed me of the provisions of this plan.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the care provider to disclose to Olympia Limited Health Services Organization, Inc. ("Olympia") or their authorized representative information including copies of records concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs. I understand information obtained with my authorization may be re-disclosed by Olympia as permitted or required by law and, therefore, are no longer protected by the federal privacy laws. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. This authorization is valid from the date signed and, provided Olympia approves coverage, until termination of the policy.

Applicant Signature: _____

Date Signed: _____

G. ANNUAL BILLING INFORMATION (*Premiums are guaranteed for one (1) year:*)

PAYMENT METHOD:

CHECK (Payable to *Olympia LHSO, Inc.*)

CREDIT CARD (Visa or MasterCard)

Card Holder Name (*If different than Applicant*): _____

Card Holder Signature: _____

Charge to my: MasterCard Visa

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Card Expiration Date:

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Month Year

Payment Amount: \$ _____

DIRECT BANK PAYMENT (ACH): **Savings Account** **Checking Account**

Account Holder Name (*If different than Applicant*): _____

Account Holder Signature: _____

Bank Name: _____

Bank Routing Number (ABA): _____

Bank Account Number: _____

Payment Amount: \$ _____

This section is to be completed by an Olympia LHSO, Inc. registered agent.

H. AGENT STATEMENT: I have reviewed this application to ensure that all required items have been completed.

Agent Name Printed: _____

Agent #: _____

Agent Signature: _____

ANNUAL PREMIUM RATES

TYPE OF COVERAGE	DENTAL As of July 1, 2009			
	Plan 5000	Plan 5500		Discount Plan 4500
Individual	\$185.40	\$277.80		\$84.00
Member/One Dependent	\$218.40	\$297.60		\$84.00
Family	\$277.80	\$349.80		\$84.00