bellevue park dental

[FAMILY & COSMETIC DENTISTRY]

Family Plan Application

All fields are required.

Last Name	First Name		Middle Initial	Gender: M/F
Home Address	City	State	Zip	Phone No.
Employer				Work No.
E-mail Address By providing my email address, I agree to recieve communications regarding my dental care via e-mail. I may revoke this authorization at any time by contacting Bellevue Park Dental.				Date of Birth

Reason for Application : ☐ New Enrollment ☐ Change of Dependent(s)

Plan Chosen: ☐ 1 Year ☐ 2 Years
☐ Individual Plan ☐ Family Plan Up to 3 Dependents

Automatic Renewal: ☐ Yes ☐ No

Please list all eligible dependent(s) to be covered under this policy.
Proof of eligibilty coverage is not required upon application, but may be requested periodically.

First Name	Last Name	Date of Birth	Relationship to Applicant (Spouse, Domestic Partner, or Dependent Child)	Gender M/F	Disabled Child Yes/No

Plan Exclusions and Limitations

- Demonstration of non-compliance with recommended course of treatment
- Services which in the opinion of the attending dentist are neither necessary nor recommended for patient's dental health
- Fluoride application is limited to one per year to age 18.
- Loss or theft of dentures or bridgework
- Denture relines are limited to one per arch in any 12 month period.
- Services which cannot be performed because of general health, physical or psychological limitation of patients
- Services performed by a non-participating provider are not covered
- Not to be combined with any other dental coverage
- Services that are not performed in our facility
- Plan cannot be combined with any other dental discount or coverage.

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Your membership will be automatically renewed every year. You can cancel your membership at the end of your 1 year period. However, you will be ineligible for re-enrollment for two years from date of termination.

Payment Instructions

A check may be submitted for the first payment on your policy. Thereafter, all premiums must be paid using Electronic Funds Transfer (EFT) from your credit card or checking account. Payments will be withdrawn every year.

Please complete the following information for payment by EFT:

Type of Account (Choose one) ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover/Novus
☐ Checking ☐ Cash

Name on Account ______________________________

Card Number ______________________________

Expiration Date ______________ CW2 Number ______________

Name of Financial Institution ______________________________

Financial Institution's City, State, & ZIP Code ______________________________

Bank Routing Number ______________ Bank Account Number ______________

Please attach a voided check to this aplication if you will be using your checking account for automatic payments.

I hereby authorize Bellevue Park Dental to initiate debit entries from my above credit card or bank account

Signed : ______________________________ Date: ______________

Your payment must be made by scheduled electronic withdrawal from your credit card or checking account.
Your payment for the upcoming renewal period will be deducted from your account one week before your policy expires.
If there are insufficient funds in your account for payment of premium on due date, payment will be due at time of 1 year recare appointment.
If there are still insufficient funds, Bellevue Park Dental will immediately terminate your contract for nonpayment of premium, effective the last day of the period for which payment was received.

In making this application to Bellevue Park Dental for Family Plan under this policy, I agree and understand that this application will become part of this policy and I agree to be bound by the terms of the policy issued by Bellevue Park Dental. I further agree that the membership requested is subject to the approval of Bellevue Park Dental and that no representative has the authority to make changes or modify this application for membership.

I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge.
I further understand that misinterpretation of submitted data may cause this application and subsequent policy to be null and void.

I have read and understand all terms, plan exclusions and limitations.
Your policy will become effective upon receipt of your first membership premium.

Signed : ______________________________ Date: ______________