Plans Underwritten by:

Dentcare

Administered by:

healthplex

Dentcare Delivery Systems, Inc.
1985 Marcus Avenue, Suite 110
New Hyde Park, NY 11042
P 800-468-0466
yourdentalplan.com/healthplex

Member Information

Group Name	Group Number	Effective Date
Nassau County Retired Union Members	64166	

Last Name	First Name	M.I.	SSN/ID #

Address	City	State	Zip Code

Home Phone	Email Address	Gender	D.O.B.

Other Dental Coverage	Name of other plan (REQUIRED for paperless billing)
Yes ☐ No ☐	

Marital Status

☐ Single ☐ Domestic Partners ☐ Married ☐ Divorced/Widow

Spouse/Domestic Partner

Last Name, First Name	Gender	D.O.B.

Dependents To Be Covered - *Dependent Children are covered up to age 19, or up to age 25 if a full-time student.*

Last Name, First Name	Gender	D.O.B.

Select One Plan

☐ Managed Care Plan ☐ PPO Plan

Dental Selection - *Please choose one Primary Care Dentist (PCD) from the Dentcare Comprehensive Directory (one PCD per family)*

Dentist Name	Dentist Site Code

Please See Reverse Side for Payment Information

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Payment Options

☐ Check enclosed in the amount of $_____ payable to **Dentcare Delivery Systems, Inc.** **Monthly Premium Rates: $70.00**

Easy Pay Update

Payment Source:
Check the box next to your desired source of payment and fill in related information. Only one payment source allowed.

☐ **Pay with Checking Account**

Account Holder:

Bank Account #

Bank Routing #

☐ **Pay with Credit/Debit Card**

Account Holder:

Credit Card #

Verification # Exp Date:

Billing Address: Street Address: City: State: Zip Code:

Terms of Service:
I hereby authorize Dentcare to initiate recurring deductions for premiums and fees, from the payment source specified. I understand that should there be insufficient funds. I will incur a service charge for any withdrawal not honored and that any changes to my policy may result in changes to the charged amount. This authority is to remain in effect until revoked by me providing Dentcare with 30 days written notice.

Paperless Billing: Email (optional): Notices prior to scheduled payments will be sent to this email address.

Signature: Date: Print Name: Signature:

To make your initial payment please send check or credit card information along with your enrollment form.

To make all monthly payments thereafter please continue to send a check or you may pay your bill online. Go to www.payyourplan.com and click on "Dentcare". Log into yourdentalplan.com/healthplex to make a payment and/or set up auto pay.

You can also email hplxenrollments@uhc.com to request assistance in processing your payment online.

Mail check to: Dentcare Delivery Systems, Inc., P.O. Box 70273, Philadelphia, PA 19176-0273. Include Group # on check memo.

By signing below, I acknowledge that I have read and agree to the terms and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date

Please Print Name