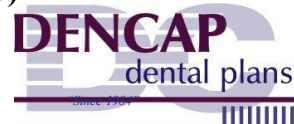


DENCAP DENTAL PLANS ENROLLMENT APPLICATION: Senior Value Dental Plan (S-5)



LAST NAME (Print)		FIRST	INITIAL	DATE OF BIRTH			SEX		SOCIAL SECURITY #		
				MO	DAY	YEAR	M	F			
STREET ADDRESS			Apt.#	HOME PHONE				DENTAL OFFICE SELECTED:			
CITY		STATE		ZIP			#				
LIST ALL DEPENDENTS TO BE COVERED BELOW INCLUDE LAST NAME IF DIFFERENT FROM SUBSCRIBER							EMAIL:				
							DATE OF BIRTH		SEX		SOCIAL SECURITY NUMBER
SPOUSE											
CHILD ONE											
CHILD TWO											
CHILD THREE											

Mail completed and signed application (front and back) to:

DENCAP Dental Plans
45 East Milwaukee
Detroit MI 48202-3231
(313) 972-1400
Fax: 972-4662
www.dencap.com

AGENT (if applicable):

Signature: _____ Date: _____

DENCAP DENTAL PLANS ENROLLMENT APPLICATION continued...

SENIOR VALUE DENTAL PLAN—Payment Options. Note that Monthly Payment is only available by Credit Card or Bank Draft.

MONTHLY PAYMENT BY CREDIT CARD (*sign below*):

5th day of every month 25th day of every month AMEX
 Single \$22.00 Two Persons \$37.00 Family \$49.00 Visa
 EXPIRATION DATE: _____ Mastercard
 Discover

CREDIT CARD NUMBER: _____

CARD HOLDER'S NAME (PLEASE PRINT): _____

CARD HOLDER'S ADDRESS (IF DIFFERENT): _____

MONTHLY PAYMENT BY ACH (Bank Draft) (*sign below*):

5th day of every month 25th day of every month
 Single \$22.00 Two Persons \$37.00 Family \$49.00

Be sure to enclose voided check or bank letter spec sheet.

NAME OF BANK: _____ ACCOUNT HOLDER'S NAME: _____

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

ANNUAL PAYMENT BY CHECK OR MONEY ORDER

Single \$264.00 Two Persons \$444.00 Family \$588.00

Be sure to enclose check or money order.

I authorize payment on my credit card (if applicable) or Bank Draft (if applicable) by signing below. I understand that my premiums will be charged to my credit card (if applicable) or Bank Draft (if applicable) the month prior to coverage effective date. If this is not possible due to payment date selected, first withdrawal will be for 2 months' coverage. I understand that I am responsible for the co-payments on all services received as specified in the Schedule of Benefits & Co-payments and for full payment of all other non-covered dental services. I also understand refunds are not issued after thirty (30) days of enrollment or after use of the plan. I am responsible for notifying DENCAP of changes in coverage.

Signature: _____ Date: _____