FOR OFFICE USE ONLY

PLAN ID#_____ PLAN EFFECTIVE DATE_____ POLICY #_____(SSN)

COUNTY:_____ LICENSED AGENTS SIGNATURE OF APPROVAL_____

Application for Prepaid Dental Plan "Plan"

Insured by: Sterling Dental of North America, LLC dba Sterling Dental

Completed Application to be returned to:
PO Box 891630 * Oklahoma City, OK 73189-1630
Phone: 866.632.8882 Fax: 866.346.6851

Resident Conditions
___Tube Feeder NPO
___ Tube Feeder not NPO
___ Tracheotomy
___Ventilator
___ HIV
___ Dementia
___ Alzheimer's

PROPOSED INSURED (person who receives dental care)
Name: _____
Sex: __Male __Female SSN: _____ DOB: _____
Medicaid Number: _____ Medicare Number: _____

PAYOR TYPE
____Medicaid
____Private

APPLICANT **(responsible person, if other than proposed Member, who is signing application on behalf of proposed Insured)**
Name: _____ Relationship: _____
Address: _____ Phone: _____
City:_____ State: _____ Zip: _____

PAYMENT METHOD **(Person making premiums on behalf of insured)**
___Gold Plan $140.00 (KGOLD081716)
Send Bill to: ___Responsible Party ____Facility (c/o Resident) ____Facility/Trust ____Facility Pay

FACILITY WHERE PROPOSED INSURED RESIDES
Name: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

APPLICATION SIGNATURE
I understand that coverage will not be effective until this application and applicable payment has been received and accepted. I authorize any dentist to provide the Company, its agents, employees, affiliates, designees, or its administrators involved in evaluating determining, or administering benefits, information concerning advice, care, or treatment provide under the plan.

Proposed Member/Responsible Party Signature:_____ Require

AUTO PAYMENT AUTHORIZATION
I (We) hereby authorize Sterling Dental of North America, LLC dba Sterling Dental to initiate debit entries to my (our) checking account at the BANK indicated on the attached void check that is made part of this application. This authorization is to remain in full force and effective until Sterling Dental and BANK receive written notification from me (or either of us) of its termination. By signing below I am representing that I am an authorized signatory on the account referenced by the attached VOIDED check.

Auto-Payment Authorization Signature:_____**Date:**_____ Recommen

*****INCLUDE COPY OF VOIDED CHECK FOR AUTO-PAYMENT*****

CONSENT AUTHORIZATION

1. I hereby authorize doctor or designated staff of Sterling Dental of North America, LLC dba Sterling Dental to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of above listed proposed insured's dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me, and/or the proposed insured, and to employ such assistance, as required, to provide proper care. I understand that no procedures will be performed prior to obtaining authorization from the responsible party, Long Term Care Facility (if trust) or proposed insured.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.
4. I hereby authorize designated staff of Sterling Dental of North America, LLC dba Sterling Dental to make request with appropriate regulatory agencies regarding the status of Medicaid adjustments and payments.

Proposed Member/Applicant Signature:_____ **Date:**_____
Responsible Party Signature:_____ **Name:**_____ Require