FOR OFFICE USE ONLY

PLAN ID#_____ POLICY #_____ (SSN)_____

PLAN EFFECTIVE DATE_____ LICENSED AGENTS SIGNATURE OF APPROVAL_____

COUNTY:_____

Application for Prepaid Dental Plan "Plan"

Completed Application to be returned to:

Sterling Dental Services, LLC

PO Box 891330, Oklahoma City, OK 73189-1330

Phone: 405.728.1278 or 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: ____ SSN: _____ DOB: ___/_____/_____

Medicaid Number: _____ Medicare Number:_____

APPLICANT (responsible person, if other than proposed Member, who is signing application on behalf of proposed Insured)

Name:_____

Relationship:_____

Address:_____

Phone:_____ or _____

City:_____ State:_____ Zip:_____

PAYOR TYPE

___Medicaid
____ SSI
____ Private
____ Trust
____Facility Pay

PAYMENT METHOD (Person making premiums on behalf of insured)

_____Basic Plan (BPA022707) ____Premium Plan (PPA022707)

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.

Required

Proposed Member/Responsible Party Signature:_____

AUTO PAYMENT AUTHORIZATION

I (We) hereby authorize Sterling Dental Services 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 Services 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.

Recommended

Auto-Payment Authorization Signature: _____ Date:_____

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

TREATMENT CONSENT AUTHORIZATION

Consent for Treatment:

1. I hereby authorize doctor or designated staff of Sterling Dental Services 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 Sterling Dental Services will not perform procedures 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.

Required

Proposed Member/Applicant Signature:_____ Date:_____

Responsible Party Signature:_____ Name:_____