



The enrollment form and 1st month's premium and fees through Electronic Funds Transfer Authorization, Check or Credit Authorization, are required to put your coverage in force.

On Your Side[®]

Insured Coverage Information (please print clearly or type)

Full Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated
Street Address	City	ST	Zip
Home Phone ()	Birth Date (MM/DD/YYYY)	Social Security #	

Check Type of Coverage and Plan Selected

Type of Coverage:	
Insured Only	<input type="checkbox"/>
Insured Plus One	<input type="checkbox"/>
Insured Plus Family (insured plus 2 or more)	<input type="checkbox"/>
Plan Selection:	
Classic \$1500 Plan	<input type="checkbox"/>
Classic \$2000 Plan	<input type="checkbox"/>
Classic Select \$1500 Plan	<input type="checkbox"/>
Classic Select \$2000 Plan	<input type="checkbox"/>
PPO Advantage Plan	<input type="checkbox"/>
Requested Effective Date (MM/DD/YYYY):	/01/
(Policy issued the first of the month only)	

Calculate Monthly Dues

Monthly Premium	\$
(Refer to Rate Guide for monthly premium)	
Monthly Admin. Fee	\$ 5.00
Monthly NSBA Fee* +	\$ 1.00
Monthly Total Due	\$

* The NSBA monthly membership fee is \$1.00. This fee will appear on your monthly invoice. **Participation is mandatory.** As a value added feature of Multiflex Dental, you will automatically become a member of the National Small Business Association (NSBA). You can learn more about the non-insurance benefits and services by visiting www.nsba.net.

Dependent Coverage Information

For additional dependents, please attach a separate sheet of paper including the following information:

Relation	Name	Social Security Number XXX-XX-XXXX	Date of Birth (MM/DD/YYYY)	Gender M/F
Spouse / Domestic Partner		- -	/ /	
Child		- -	/ /	
Child		- -	/ /	
Child		- -	/ /	
Child		- -	/ /	

Payment Method (Choose one)

Electronic Fund Transfer		
I want to pay by <input type="checkbox"/> Electronic Fund Transfer (EFT). Please complete and sign Electronic Fund Transfer (EFT) form on page 2.		
Check or Money Order		
I want to pay by <input type="checkbox"/> Check or Money Order. Please bill me direct.	Make Checks payable to: Multiflex Dental	
Credit Card		
Charge my Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Credit Card #	Exp. Date (MM/YYYY)
DEDUCTION AUTHORIZATION: I hereby authorize the insurance premiums to be deducted monthly from my credit card and remitted to Multiflex Dental. This authority is to remain in effect until I cancel it by written notification to Multiflex Dental at least 31 days in advance of the intended termination date of my coverage. (Any excess premiums which may accrue after termination of my coverage will be refunded to me.)	Name as it appears on Card:	
	Card billing address:	
	Signature	Date (MM/DD/YYYY)

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Administered by Merchants Benefit Administration (MBA).

Please Sign and Date

By my signature below, I hereby apply for coverage with Multiflex Dental insurance under a Group Dental Insurance Policy. I also certify that I have read and understand the applicable Fraud Notices.

SIGNATURE

DATE (MM/DD/YYYY)

State Fraud Notice

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 subjects such person to criminal and/or civil penalties.

MULTIFLEX DENTAL ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Save time and postage by using our Electronic Funds Transfer (EFT) Service for your monthly premium and fees payment.

How Does EFT Work?

The EFT service allows you to automatically pay your insurance premiums and fees from a bank or money account of your choice. There is no fee charged by Merchants Benefit Administration for this service. We will issue instructions to your bank to forward payment on the due date of each month.

If there are insufficient funds in your account on the payment due date, your payment will be considered unpaid and delinquent. Multiflex Dental will send you a late notice should this occur. There will be a \$15.00 fee associated with an insufficient funds notification. If you choose to discontinue the EFT service, you must notify Multiflex Dental in writing at least 30 days before the next payment due date. To initiate the EFT service, complete and sign the form below.

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUND TRANSFER

NAME ON BANK ACCOUNT

NAME OF BANK

BANK ACCOUNT NUMBER

BANK ROUTING NUMBER

*You should attach or fax a voided check or savings deposit slip*TYPE OF ACCOUNT SAVINGS CHECKING

I hereby authorize Multiflex Dental to initiate EFT debit entries for the payment of insurance premiums and fees from the bank listed above. The debit entry amount will be the total of the invoice for insurance premiums and fees due each month. This authorization will remain in effect until Multiflex Dental receives written instructions from me to terminate the service.

ACCOUNT HOLDER'S SIGNATURE

DATE (MM/DD/YYYY)

Producer Information (please print clearly or type)

Producer Signature

Producer Number

For Internal Use Only

MAIL SIGNED FORM TO: 15974 N 77th St Suite 102 Scottsdale, AZ 85260

or

FAX BOTH SIDES OF THIS FORM TO: (480) 776-5050

Enrollment Form Questions?

Please call us at 1-800-445-7227, Option 3, Monday-Friday, 8:00AM-4:00PM (PST).