Mail This Enrollment Form to:
Dental Source
1722 South Glenstone, Suite W-201
Springfield, MO 65804
(417) 882-3787 or (800) 955-3471

DENTAL SOURCE
1722 South Glenstone, Suite W-201
Springfield, MO 65804
(417) 882-3787 or (800) 955-3471
Fax (417) 886-5852

AMERICAN DENTAL PROGRAM

DENTAL SOURCE

A Prepaid Dental Health Care Plan

Your SS#	Male/Female	Last Name	First Name	M

Date of Birth	Home Address	Apt. #

Zip Code	City	State	Home Telephone ( )	Work Telephone ( ) Ext.

Selected Dental Office	

Dependent Information *(limited to six members per family)*

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	Selected Dental Office

I understand the terms and conditions of the plan and I hereby adopt the plan for a one (1) year period.

AUTHORIZATION TO RELEASE DENTAL RECORDS – I hereby authorize the release and disclosure to review or to obtain a copy thereof, of any and all Dental Records which pertain to me or any member of my family maintained by my selected Primary Care Dentist and/or Specialty Care Dentist to Dental Source or any designated agent or representative for the purposes of dental treatment, care and for Dental Source Quality Assessment and Utilization Reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Subscriber's
Signature x_____ Date _____

_____ Please initial so we may represent your interests with the Home Office due to HIPAA requirements.

Yes! I want to enroll in the Dental Source, 100%-A Plan. I have checked the payment method and how many people to cover. There are two (2) methods of payment. PLEASE CHOOSE ONE.

1. ☐ **I want to pay MONTHLY by BANK DRAFT**

I hereby request and authorize you to pay checks drawn on my account provided there are sufficient collected funds in said account to pay the same upon request. Please check the number of people to be enrolled.

☐ One (Myself).....$17.60 ☐ Two (Myself – one dependent).....$25.25 ☐ Three to six.....$30.15

Please enclose a check for the first month's cost **plus $25** for the one-time enrollment fee. Make check payable to Dental Source. This same checking account will be used for future bank drafts. There will be a service charge for returned drafts. *This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or bank draft.* Bank drafts are drafted by First Continental Life Ins. Co.

2. ☐ **I want to pay ANNUALLY. (Check One)** ☐ By check. (Please enclose check payable to Dental Source OR by Credit Card ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card's expiration date _____ Name As It Appears on Card _____

Please check the number of people to be enrolled. Account Number | | | | | | | | | | | | | | | | |

☐ One (Myself) .....$211.20 ☐ Two (Myself + one dependent) ..... $303.00 ☐ Three to six $361.80

If paying by check, please enclose the first year's cost **plus $25** for the one-time enrollment fee.

*There will be a service charge for returned checks.

OFFICE USE ONLY	4W ENTERPRISES SPRINGFIELD – AGENT	GA 4W#9289	AGENT 8736