

Administered by:

Dutcher Insurance Agency, Inc.

Since 1970 ...
Over 30 years of Quality Service
Lic. CA #0561264 NV #16010

SELECT DENTAL
for Individuals and Families.



Sierra Vista Marketing

Fully Insured by:
SafeHealth Life



SafeGuard

ENROLLMENT FORM

Requested Effective Date:

For Members of the National Council of Independent Consumers Association

If the enrolling member is less than 18 years of age, application must be completed providing Social Security Number for child and signed by parent having custody or legal guardian.

Name of Applicant Last	First	Initial	Social Security Number	Phone Number
Home Address of Applicant			County	Occupation
City			State	Zip

RELATIONSHIP	NAME(S) OF PERSONS APPLYING	SEX	AGE	DATE OF BIRTH
Applicant				
Spouse				
Child				
Child				
Child				

Any Dependent Child ages 19-23 (19-25 if Texas resident) must be a full time student attending an accredited educational institution. Please provide the following information and enclose a copy of current schedule (12+ units).

Name of Accredited Educational Institution: _____ Number of Hours and/or Units _____

I Declare all statements on this enrollment form are true and complete and I understand they are the basis on which coverage may be issued under the plan. I Declare that I have read and understand the Select Dental brochure.

Applicant's Signature: _____ Date: _____

Signed at (City/State): _____

PRODUCER INFORMATION

Name _____ Company _____

Address _____ City/State/Zip _____

Telephone () _____ Fax # _____

Make Commissions payable to: _____ E-mail address _____

Address _____

I hereby certify that I have assisted the applicant in completing the enrollment material, and that I have truly and accurately recorded hereon the information supplied by the applicant, I further certify that I have explained all benefits and exclusions and limitations in the selected plan.

Agent's Signature _____

General Agency (if applicable) _____

Has agent completed and enclosed the necessary Agent Appointment forms? Yes No

PAYMENT OPTIONS/PREMIUM CALCULATION

Make checks payable to: **DUTCHER INSURANCE AGENCY INC.**

Mail to: DUTCHER INSURANCE AGENCY, INC. • 7510 SHORELINE DRIVE, SUITE A-1, STOCKTON, CA 95219

MONTHLY AUTOMATIC CHECK PLAN

If Monthly Automatic Check mode is preferred, two premiums and two Association Fees are due with the application, and the insured MUST complete the Automatic Payment/Draft Authorization below, and attach a voided check.

Premium Amount	\$		x 2	=	\$	
Association Fee	\$	2.00	x 2	=	\$	4.00
Initial Enrollment Fee				=	\$	10.00
TOTAL AMOUNT DUE WITH APPLICATION					=	\$

Automatic Payment/Draft Authorization

Please Enclose a VOIDED check - Deposit Slips ARE NOT ACCEPTABLE

AUTHORIZATION TO HONOR CHECKS DRAWN BY: DUTCHER INSURANCE AGENCY, INC.

As a convenience to me, I hereby request and authorize you to pay my account, checks drawn on my account by and payable to the order of Dutcher Insurance Agency Inc., provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed by me. 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.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of benefits.

TO:

Bank
Address
Name of Account

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Bank / Routing Number

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Account Number

Signature EXACTLY as it appears on bank records	Date
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INSTRUCTIONS FOR USAGE AND AUTHORIZATION

TO: The Bank Named

So that you may comply with your depositor's request, this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed by this company and received by you in the regular course of business for the purpose of payment (under this plan), including any costs or expenses reasonably incurred in connection herewith.
2. In the event that any such check, draft or order shall be dishonored whether with or without cause, whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of insurance or other right.
3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request or in any manner arising by reason of your participation in the foregoing plan of payment collection.

QUARTERLY BILLING

Premium Amount	\$		x 3	=	\$	
Association Fee	\$	2.00	x 3	=	\$	6.00
Initial Enrollment Fee				=	\$	10.00
Billing Fee				=	\$	15.00
TOTAL AMOUNT DUE WITH APPLICATION					=	\$

SEMIANNUAL BILLING

Premium Amount	\$		x 6	=	\$	
Association Fee	\$	2.00	x 6	=	\$	12.00
Initial Enrollment Fee				=	\$	10.00
Billing Fee				=	\$	15.00
TOTAL AMOUNT DUE WITH APPLICATION					=	\$