Dushore Dental Services

The Practice of Jerome H. Plastow D.M.D.

DENTAL HEALTH PARTNERSHIP

Enrollment Form

☐ **New Application**
☐ **Renewal**

Enrollment Period
(Patients are eligible for benefits for 12 months beginning on first day of enrollment month.)
☐ July 1, 20____ ☐ Jan. 1, 20____

Primary Applicant Information

Last	First	MI	DOB	SS#

Address	City	Zip

Home Phone	Work Phone	Cell Phone	Email

Plan

SINGLE PLAN	Annual Fee	**DUAL PLAN**	Annual Fee	**FAMILY PLAN**	Annual Fee
☐ Adult (age 18 and up)	$275	☐ Husband/Wife	$530	☐ Family Plus (each additional dependent age 23 and under)	$175 each
☐ Adult Dependent (ages 18-23)	$275	☐ Parent/1 Dependent (ages 18-23)	$530	☐ Parents/1 Dependent (ages 18-23)	$795
☐ Child (age 17 and under)	$200	☐ Parent/ 1 Child (age 17 and under)	$455	☐ Parents/1 Child (age 17 and under)	$720

Family Information

Gender	Relationship Spouse,Child, Dependant	Last Name	First Name	M.I.	D.O.B.	Age at start of Enrollment Period if child or dependent
☐ Male ☐ Female						
☐ Male ☐ Female						
☐ Male ☐ Female						
☐ Male ☐ Female						
☐ Male ☐ Female						
☐ Male ☐ Female						
☐ Male ☐ Female						
☐ Male ☐ Female						

I am requesting coverage for myself and the above-named individuals. I attest to and I understand the following (Please check that you have read and understand each line):

___ That I represent the above-named individuals and that the above-named individuals are dependent upon me
___ That all information is true and complete. I understand that it is crime to knowingly provide false, incomplete or misleading information to a health care provider for the purpose of attaining benefits.
___ That I have read all the terms and conditions of this DHP and I enter into this DHP willingly.
___ That all benefits are subject to the terms and conditions stated in the Information and Coverage Document
___ That in signing this application I represent that I have read and understand all the information provided to me about the DHP through Dushore Dental Service and the practice of Jerome H. Plastow D.M.D.
___ That this is an agreement between provider and patient which eliminates any third-party responsibility and payments.
___ That this DHP is a discount plan, not a dental insurance plan. Preventative treatments are coverage as outlined in DHP information and other treatments are discounted.
___ That this DHP is only for services performed by Jerome H Plastow D.M.D. and cannot be used for services provided by any other dentist, dental office, dental specialist, hospitalization or dental hospital charges
___ That benefits cannot be used in conjunction with other dental plans, for services covered under Workman's Compensation or automotive dental or medical coverage
___ That treatment, which at the sole opinion of the treating dentist, lies outside of the realm treating dentist
___ DHP member benefits are for one full year starting on date of enrollment period and that benefits are non-refundable, non-transferrable and non-redeemable if unused. (see DHP Exclusions and Limitations)
___ That I am responsible for full payment of annual fee at the time of enrollment and that there are no pro-rations for less than a 12 month period.
___ That after enrollment, there are no refunds if patient should change their mind about enrollment or if any benefits are unused during 12 month period.

Primary Applicant's
Signature_____Date_____

Spouse Signature_____Date_____

For Office Use Only
Plan Annual Fee:
Type of Payment: □ Cash □ Check □ Credit Card □ Debit Card
Date of Payment:
Amount Paid:
Processing Associate: