

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: \_\_\_\_\_ Fax: \_\_\_\_\_

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: Smile Saver**

**We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.**

**If you have questions please contact our office at:**

Thank you for choosing...

**SmileSaver**

# PLAN STERLING 6500 ENROLLMENT FORM

<b>1 MEMBER INFORMATION (PLEASE PRINT)</b>			
LAST NAME	FIRST NAME	HOME PHONE (    )	WORK PHONE (    )
HOME ADDRESS		CITY	STATE
SOCIAL SECURITY #		BIRTHDATE	VISION CODE
		<b>SEE PROVIDER DIRECTORY FOR I.D. CODES:</b>	DENTAL CODE
<b>2 PURCHASER'S INFORMATION (COMPLETE ONLY IF DIFFERENT THAN MEMBER INFORMATION)</b>			
LAST NAME	FIRST NAME	HOME PHONE (    )	WORK PHONE (    )
HOME ADDRESS		CITY	STATE
SOCIAL SECURITY #		BIRTHDATE	VISION CODE
		<b>SEE PROVIDER DIRECTORY FOR I.D. CODES:</b>	DENTAL CODE
<b>3 PROVIDE ALL INFORMATION FOR ELIGIBLE PERSON TO BE COVERED</b>			
SPOUSE LAST NAME		FIRST NAME	
SOCIAL SECURITY #		BIRTHDATE	VISION CODE
		<b>SEE PROVIDER DIRECTORY FOR I.D. CODES:</b>	DENTAL CODE
<b>4 PAYMENT METHOD</b>			
<input type="checkbox"/> Monthly By Credit Card <b>complete Sections 4, 5, &amp; 7</b> <input type="checkbox"/> Annual By Credit Card <b>complete Sections 4, 6, &amp; 7</b> <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover/NOVUS <input type="checkbox"/> AMEX Card # _____ Exp _____ Name on Credit Card _____ Signature for credit card purchase _____		<input type="checkbox"/> Monthly Automatic Bank Debit <b>complete Sections 5 &amp; 7</b> (To begin automatic bank debit, enclose a check for first month's premium plus application fee) <input type="checkbox"/> Annual by Check <b>complete Sections 6 &amp; 7</b> <input type="checkbox"/> Annual by Money Order <b>complete Sections 6 &amp; 7</b>	
<b>MONTHLY</b>		<b>ANNUAL</b>	
<b>5 Dental with Vision</b>		<b>6 Dental with Vision</b>	
Member only.....	\$6.75	Member only.....	\$72.00
Member & one.....	\$10.25	Member & one.....	\$114.00
I decline Signature Vision Plan (50¢ per month covers one or two members)	— .50	I decline Signature Vision Plan (50¢ per month covers one or two members)	— 6.00
One-time application fee (non-refundable)	+\$16.00	One-time application fee (non-refundable)	+\$16.00
TOTAL AMOUNT ENCLOSED	\$ _____	TOTAL AMOUNT ENCLOSED	\$ _____
*(Enclose check or credit card number for payment that covers first month's premium + application fee.)		*(Enclose check, money order or credit card number for payment to cover premium + application fee.)	
<b>Sign automatic payment authorization to authorize monthly deductions.</b> <b>AUTOMATIC PAYMENT AUTHORIZATION:</b> I hereby authorize GE Wellness Plan Dental and Vision (GEWPDV) to debit my checking account or charge my credit card each month the applicable monthly premium to be credited to my GE Wellness Plan Dental and Vision membership. This authorization will remain in effect until I notify GEWPDV, in writing, 30 days prior to termination. My bank is authorized to make any necessary corrections. I understand there is a nonrefundable service charge of 50 cents included in the monthly premium.  Name as it appears on check or credit card: (Print) _____  Signature: _____  Date _____  <b>Proceed to Section 7 Acknowledgement.</b>		<b>7 ACKNOWLEDGEMENT</b> (Be sure to sign to complete enrollment.)	
		I WISH TO ENROLL IN THE GE WELLNESS PLAN DENTAL AND VISION PLAN AS INDICATED. I ACKNOWLEDGE THAT I HAVE READ THE ENCLOSED INFORMATION. I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS TRUE AND COMPLETE. I AGREE TO BE BOUND BY THE TERMS AND CONDITIONS OF THE GE WELLNESS PLAN DENTAL AND VISION PLAN. BY SIGNING THIS CONTRACT, I AM AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND I AM GIVING UP MY RIGHT TO A JURY OR COURT TRIAL. (SEE THE GRIEVANCE PROCEDURE SECTION IN THIS DISCLOSURE FORM.)	
Agent Code#: _____ Agent Name: _____		Member's Name _____ PLEASE PRINT	
Agent Phone: _____ FOR INTERNAL USE ONLY		Member's Signature _____	
		Date _____	
		Mail to: GE Wellness Plan Dental and Vision File 56748 Los Angeles, CA 90074-6748	