Individual Select Dental Application

(Maryland Residents)

OFFICE USE ONLY:

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

The Dental Network

The Dental Network, Inc.
1946 Greenspring Drive, Timonium, MD 21093

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign and return this application in the postage-paid return envelope.

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and delay your coverage.***

For Faster Processing Please Make Check Payable to:
THE DENTAL NETWORK, INC. and mail to:

THE DENTAL NETWORK
P. O. BOX 79810
Baltimore MD 21279-0810

Questions! Call Tom @ tel: (888)490-8782
or email: insurance@rxmom.com

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #

Residence Address (Number and Street, Apt. #)	(City and State)	Zip Code (9-digit, if known)

Billing Address, if different from Residence Address: (Number and Street)	(City and State)	Zip Code (9-digit, if known)

Date of Birth	Sex	Marital Status	Plan Type
/ /	☐ Male ☐ Female	☐ Single ☐ Married/Partner	☐ Annual ☐ Semi-Annual

Home Phone	Work Phone	E-Mail Address
( )	( )	

2. Coverage selection: (Check one)

☐ **Individual** - Provides coverage for one person
☐ **Individual & Child(ren)** - Provides coverage for an individual and eligible dependent(s)
☐ **Individual & Adult** - Provides coverage for two eligible adults
☐ **Family** - Provides coverage for two eligible adults and eligible dependent(s)

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child/ren, Individual & Adult or Family Coverage

(DHMO Plan must have a dental code. Each person can select their own dentist.)

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	Dental Office Code
Member						☐M ☐F	
Spouse/Partner						☐M ☐F	
Dependent 1						☐M ☐F	
Dependent 2						☐M ☐F	
Dependent 3						☐M ☐F	
Dependent 4						☐M ☐F	

4. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED. **YES** **NO**

Is anyone listed on this application covered by other dental insurance, including other Blue Cross and Blue Shield coverage? ☐ ☐

If yes, please provide the following:

Name of family member(s) _____ Insurance Company _____

Policy Number and Type _____ Effective Date _____

5. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.

This information is subject to verification. Failure to complete any section may delay the processing of your applicaton and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

Premium payment options are available on an annual and a semiannual basis. Those members who elect the semiannual payment option will be subject to a five dollar ($5) surcharge per payment, which equates to ten dollars annually.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for The Dental Network policy.

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED UNDER THIS AGREEMENT, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS APPLICATION.

WARNING: It is a fraudulent insurance act for a person knowingly or willfully to make a false or fraudulent statement or representation in or with reference to this application for insurance.

Signature of Applicant: X_____ Date:_____

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Parent or Legal Guardian's Signature: X_____ Date:_____

Please make checks payable to:

THE DENTAL NETWORK, INC.
and mail to:

P.O. Box 79810
Baltimore, MD 21279-0810

FOR INTERNAL USE ONLY:

Agency Name	RxMom.com Insurance Service Agent Thomas Musembi AGENT #20200		
Agency Address (Number and Street, Apt. #)	(City and State)		Zip Code (9-digit, if known)
4800 Hampden Ln Suite 200	Bethesda MD		20814
Telephone Number	Fax Number	E-mail Address	
(888) 490-8782	(866) 707-9532	insurance@rxmom.com	
Annual Premium			

Individual Select Dental HMO Rates
Maryland

Coverage Type	Annual Rate Full Annual Payment Due with Enrollment Application
Individual	$120
Individual & Child	$204
Individual & Adult	$240
Family	$360

Coverage Type	Semi-Annual Rate Second Payment Due by the 1st of the fifth month from the effective date of coverage	
	1ST PAYMENT	2ND PAYMENT
Individual	$65	$65
Individual & Child	$107	$107
Individual & Adult	$125	$125
Family	$185	$185

Please note that when selecting the semi-annual payment, a $5.00 administration fee is already included into each payment. You pay an additional $10/year when you select the semi-annual payment option. The first payment (of the semi-annual rate) is due with the enrollment application. The second payment is due by the 1st of the fifth month from the effective date of coverage.

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The Dental Network is an independent licensee of the Blue Cross and Blue Shield Association.
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