TakeCare℠

Supplemental Dental 2020

Application and Direct Payment Form

***You and your dependent must be enrolled in the FEHB TakeCare High Option, Standard Option, or HDHP Option to be eligible for the TakeCare Supplemental Dental Plan.**

st Name _____ First Name _____ M.I. _____ Social Security _____ Date of Birth _____

La _____ ❒ Male ❒ Female

iling Address (P.O. Box/Street) _____ State _____ Zip Code _____

Ma _____

me Telephone Number _____ Work Telephone Number _____ Email _____

Ho

Please indicate below the name of your dental insurance, if you or any of your dependent(s) have other coverage:

❒ _____ Effective Date / /

❒ _____ Effective Date / /

Please list yourself and all family members you wish covered under the Supplemental Dental Plan:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY	RELATION	SEX.	D.O.B.	TAKECARE USE ONLY

I understand that TakeCare reserves the right to refuse participation by any applicant in the plan and is not obligated to provide a reason for declining coverage. I further understand that application does not guarantee acceptance into the plan; acceptance of coverage is not granted, under any circumstances, until the application has been approved by TakeCare. Note: *The Supplemental Dental benefits described in the TakeCare Federal brochure are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all Federal enrollees and family members who are members of the TakeCare plan. The cost of the benefits for the supplemental dental plan is not included in the FEHB Premium.* ***Enrollment in the TakeCare Supplemental Dental Plan is locked-in for the benefit year.*** *Voluntary Disenrollment is only allowed during the plan year if I terminate employment with the Federal Government or cancel my enrollment in the FEHB TakeCare High Option, Standard Option or HDHP Option.*

I (we) hereby authorize TakeCare Insurance Company, hereinafter called the **COMPANY**, to initiate monthly debit entries for a 12 month period (locked-in provision) to our **CHECKINGS**, **SAVINGS**, or **CREDIT CARD** account indicated below at the depository financial institution/credit card company named below, hereinafter called the **DEPOSITORY** or the **CREDIT CARD**, and to debit the same to such account by the 20th of the month. I (we) acknowledge the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with U.S. law.

Monthly Payment (Select One)

❒ **$39.90 Self Only** Coverage Monthly ❒ **$79.80 Self Plus One** Coverage Monthly

❒ **$126.35 Self and Family** Coverage Monthly

Payment Method (Select one - Checking Account, Savings Account or Credit Card)

❒ CHECKING ACCOUNT ❒ SAVINGS ACCOUNT

(Attach voided copy of deposit slip or check if making changes from last plan year)

Financial Institution _____

Bank Routing Number _____

Account Number _____

❒ **CREDIT CARD** (Please indicate credit card): ❒ American Express ❒ Mastercard ❒ VISA

Credit Card #: _____ Exp. Date: _____ CVV#: _____

IF THE TRANSACTION IS DENIED AT ANY TIME, I UNDERSTAND THAT I WILL BE CONTACTED BY TAKECARE FOR AN ALTERNATIVE PAYMENT METHOD FOR THE REMAINDER OF THE 12-MONTH PERIOD.

X _____ _____

Applicant's Signature Date