

Dental Network Card Enrollment Form				Please Print
Last Name:		First Name:		MI: Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Date of Birth (MM/DD/YY):		Medicare Enrolled? <input type="checkbox"/> Y <input type="checkbox"/> N	Phone Number:	
Address:			County Name:	
City:		State:	Zip Code:	
Email Address:				
Dependents (Only required for Family Coverage)				
Name	Medicare <input type="checkbox"/> Y <input type="checkbox"/> N	Relationship	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (MM/DD/YY)
	<input type="checkbox"/> Y <input type="checkbox"/> N	Spouse	<input type="checkbox"/> F <input type="checkbox"/> M	
			<input type="checkbox"/> F <input type="checkbox"/> M	
			<input type="checkbox"/> F <input type="checkbox"/> M	
			<input type="checkbox"/> F <input type="checkbox"/> M	
Payment: <input type="checkbox"/> \$36.50 (Individual Coverage for One Year) OR <input type="checkbox"/> \$52.00 (Family Coverage for One Year)				
<input type="checkbox"/> Pay by Check ▪ Make check Payable to "Health Economics Group, Inc." ▪ Mail Payment and Enrollment form to: Health Economics Group Inc. 1050 University Avenue, Suite A, Rochester, NY 14607 Attn: Dental Network Card Program				
<input type="checkbox"/> Pay by Credit Card ▪ Mail Enrollment form to: Health Economics Group Inc. 1050 University Avenue, Suite A, Rochester, NY 14607 Attn: Dental Network Card Program OR ▪ Fax form to 585-241-9518				
Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> Discover				
Credit Card Number:				Expiration Date:
Name as it Appears on Credit Card:			Security Code:	
I authorize Health Economics Group, Inc. to use the credit card information provided above as payment for the Dental Network Card.				
Signature:			Date:	

You will receive your Dental Network Card(s) in the mail once your enrollment is processed. Please allow 10-14 business days for processing. Your card(s) will be effective on the date your enrollment is processed. Your card(s) will expire on the last day of the month following 12 full months of eligibility. **Re-enrollment is not automatic.** You must contact us to re-enroll.

For the names and addresses of DenteMax network dentists in a particular geographic area and/or to see the schedule of fees accepted by most general dentists in the network, go to www.heginc.com/dental or call Health Economics Group, Inc. at 585-241-9500 x505 or 800-666-6690 x505. We will be pleased to help you.

This is not insurance. This is not a Medicare program. Health Economics Group, Inc. does not guarantee that a particular dentist will accept DenteMax fees as payment in full. Confirm DenteMax network participation and fees **before** receiving treatment. Please note that specialists and some general dentists may charge higher fees than what is shown on the schedule. We rely on the judgment of DenteMax as to the professional competency of dentists in their network. Our role is to make the DenteMax network available to members of this program. Our liability is limited to the amount paid for the card(s).

I have read and understand the above information and I want to enroll in the Dental Network Card Program.

Signature: _____ Date: _____