



PREPAID APPLICATION

ENROLLMENT INSTRUCTIONS:

1. Complete the Prepaid Application. (Be sure to list all family members to be included).
2. Select a dental office from the Provider List, and insert the dental facility number on the application.
3. Complete the Authorization for Deduction section below. Include a check for the first month premium, payable to **CompBenefits, Inc.**
4. Return the completed Prepaid Application, Authorization for Deduction section, and first month premium check to the following:
Advantages In Membership, Inc.
2255 Collier Parkway
Land O Lakes, FL 34639

SOCIAL SECURITY #		LAST NAME		FIRST	MI	DATE OF BIRTH
HOME ADDRESS			AREA CODE	HOME PHONE	SEX M F	
CITY	STATE	ZIP CODE	AREA CODE	BUSINESS PHONE	DENTAL FACILITY #	
NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION BAY GULF CREDIT UNION - GROUP #16936				EMPLOYER'S GROUP ADMINISTRATOR		
LIST ALL YOUR ELIGIBLE DEPENDENTS IF THEY ARE TO BE COVERED AS DEFINED IN THE CERTIFICATE OF BENEFITS						
	FIRST	MIDDLE	LAST (IF DIFFERENT)	DENTAL FACILITY #	SEX	BIRTH DATE
SPOUSE:					M F	/ /
CHILD:					M F	/ /
CHILD:					M F	/ /
CHILD:					M F	/ /
COVERAGE EFFECTIVE DATE					# DEPENDENTS COVERED	
PLAN CODE CS250		GROUP CODE # 16936		PREMIUM AMOUNT \$	AMOUNT PAID \$	Agent Code 0304028RL
THIS MEMBERSHIP AGREEMENT IS NOT EFFECTIVE UNTIL YOU RECEIVE YOUR AGREEMENT AND CERTIFICATE OF BENEFITS.						

Completed application, authorization for deduction form, and first month premium payment must be received by the CompBenefits Home Office by the 11th of the current month to ensure the 1st of next month eligibility.

Any person with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I wish to enroll in the CompBenefits Plan. I understand that this is a minimum one (1) year contract and that all necessary dental services will be provided in the description of benefits and surcharges. I have received and understand the outline of coverage.

I hereby authorize the Group to deduct monthly for 12 months, and future renewal period(s) my portion of such subscription fee from any funds due me. I understand that enrollments are by Group contract and/or for consecutive 12 month period(s) and my subscription fee is subject to change on the anniversary date of the Group. I hereby represent to the carrier that all information furnished by me hereon is true and complete to the best of my knowledge. I here by consent, personally and on behalf of any family member enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompBenefits for, but no limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

Applicant Signature: _____ Date: _____
 Agent Signature: _____

AUTHORIZATION FOR DEDUCTION

Signature Required

I, _____ (First Name) _____ (MI) _____ (Last Name) _____ (Social Security Number)

authorize CompBenefits to make monthly deductions from my Bay Gulf Credit Union account for dental contributions on the 15th of each month as follows:

Deductions of \$ _____

	<u>Plan Options</u>
	Individual Plan: \$18.66
	Individual Plan + One other person: \$35.46
	Individual Plan + Two or more other persons: \$48.30

Financial Institution: Bay Gulf Credit Union ABA Routing/Transit #: 263182671 Address: 3202 W. Waters Ave. Tampa, FL 33614

Checking _____ Savings _____ Account# 053 _____

Credit Union Contacts: Aaron Weinstock (813) 205-4228; aweinstock@baygulf.com Douglas M. Fagan; (813) 932-1301 ext. 234; dfagan@baygulf.com

The amount of deduction indicated above is approximate and may be corrected by the Dental Plan. This authorization shall cease (a) upon my giving written cancellation notice to the Dental Plan; (b) automatically upon my termination as an employee, member or depositor, as the case may be, of the above named Financial Institution; (c) automatically upon termination of my checking, savings account listed above as this authorization relates to such an account; or (d) upon discontinuance of the deduction and remittance arrangements between the above named Financial Institution and the Dental Plan. I understand this authorization does not waive or change any of the payment provisions of any certificate issued to me by the Dental Plan and if this authorization terminates for any reason, any further payments required under said certificate(s) shall be made as provided in the certificate(s).

Signature: _____ Date: _____