





# LIST BILL PAYMENT AUTHORIZATION FORM

Company Name \_\_\_\_\_ Date \_\_\_\_\_

Authorizing Agent: \_\_\_\_\_ Title \_\_\_\_\_

Mailing Address \_\_\_\_\_ E-Mail Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

By signature below, the company authorizes Direct Dental Plans of America, Inc. to process the initial payment indicated and approved on the "List Bill Application" and for all monthly payments thereafter from the account indicated below. Monthly payments will be processed on the 6<sup>th</sup> day of each month. The monthly draft amount may vary due to employee termination and/or new enrollments.

Company agrees to notify Direct Dental Plans of America of any employee terminations in writing. Terminations require a 30 day advance notice to be removed from the billing cycle. Credits or refunds will not be issued for employee terminations that have not been reported in writing. Applications for new enrollees may be faxed to 303-457-6956. Employees enrolling prior to the 15<sup>th</sup> of the month will have the initial payment processed immediately upon receipt. The monthly draft amount will then be amended to reflect the addition of the new application amount for the next consecutive month. Employees who enroll after the 15<sup>th</sup> of the month will have the initial monthly payment processed along with the monthly draft during the next draft cycle.

**SELECT A METHOD OF PAYMENT: (Check One and Provide All Required Information):** Please note that business accounts can be billed at the beginning of every month, for check payment processing. If you prefer to receive a bill, please contact our office at 303-457-9497.

**AUTOMATIC CREDIT CARD PAYMENTS**

NAME OF CARD: \_\_\_\_\_

CREDIT CARD #: \_\_\_\_\_ EXP DATE: \_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Authorized Signature for Credit Card (Required) Date

**BANK DRAFT PAYMENTS:**

Name on Account : \_\_\_\_\_

ROUTING # \_\_\_\_\_ ACCT. # \_\_\_\_\_

NAME OF BANK \_\_\_\_\_ BRANCH CITY \_\_\_\_\_ STATE \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature for Bank Debit (Required) Date



# APPLICATION FOR GROUP ENROLLMENT

**Member Information:**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Dependents:**

Spouse: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child : \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Child : \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child : \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Child : \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child : \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Plan Type: (Check One):**

- DDP COLORADO – Includes a King Soopers Prescription Discount Plan at No Charge!
- NATIONWIDE NETWORK (AETNA DENTAL/COAST TO COAST VISION/UHS CHIROPRACTIC)  
*This form does not apply to the United Healthcare Fully Insured Plan offer through DDP. Groups interested in this product must begin by requesting a quote and alternative applications will be required.*

**Plan Selection (Circle the initial payment on the applicable plans below):**

DENTAL RATES					DENTAL/VISION RATES					VISION ONLY RATES				
	Monthly	Quarterly	Semi-Annual	Annual		Monthly	Quarterly	Semi-Annual	Annual		Monthly	Quarterly	Semi-Annual	Annual
Member	9.80	30.90	59.80	111.60	Member	14.65	45.45	88.90	169.80	Member	4.85	14.55	29.10	58.20
Member+1	16.20	50.10	98.20	188.40	Member+1	22.95	70.35	138.70	269.40	Member+1	6.75	20.25	40.50	81.00
Member+2	21.40	65.70	129.40	250.80	Member+2	29.85	91.05	180.10	352.20	FAMILY	8.45	25.35	50.70	101.40
Member+3	25.55	78.15	154.30	300.60	Member+3	34.00	103.50	205.00	402.00	<b>CHIROPRACTIC/MASSAGE ONLY RATES</b>				
Member+4	29.75	90.75	179.50	351.00	Member+4	38.20	116.10	230.20	452.40		Monthly	Quarterly	Semi-Annual	Annual
DENTAL/CHIROPRACTIC/MASSAGE RATES					HIGH OPTION - DENTAL/VISION/CHIROPRACTIC/MASSAGE RATES					CAREMARK PRESCRIPTION CARD RATES				
	Monthly	Quarterly	Semi-Annual	Annual		Monthly	Quarterly	Semi-Annual	Annual		Monthly	Quarterly	Semi-Annual	Annual
Member	13.80	42.90	83.80	159.60	Member	18.65	57.45	112.90	217.80	FAMILY	5.70	17.10	34.20	68.00
Member+1	22.45	68.85	135.70	263.40	Member+1	29.20	89.10	176.20	344.40					
Member+2	26.40	80.70	159.40	310.80	Member+2	34.85	106.50	210.10	412.20					
Member+3	31.45	95.85	189.70	371.40	Member+3	39.90	121.20	240.40	472.80					
Member+4	36.50	111.00	220.00	432.00	Member+4	44.95	136.35	270.70	533.40					

**Broker Information:**

Broker/Agent Name: \_\_\_\_\_ DDP Producer # \_\_\_\_\_

**Payroll Deduction Authorization:**

I voluntarily agree to enroll in DIRECT DENTAL PLANS OF AMERICA, INC. I understand that DDP is not insurance and that treatment must be received by a participating provider through the DDP Dental Network. I will not hold DDP accountable for any negligence on the part of the Provider(s). I understand I am responsible for the payment of this plan through a payroll deduction for a minimum of one (1) year.

I authorize a payroll deduction in the amount of \$ \_\_\_\_\_ per month. This amount will be deducted from my paycheck beginning in the month of \_\_\_\_\_, 20\_\_\_\_.

Upon termination, I understand that I may continue with the plan as an individual by contacting DDP. If upon termination, I choose to discontinue the plan, I must return all membership cards to DDP within 30 days of termination. Failure to return membership cards within 30 days of termination indicates my desire to continue the plan through the annual renewal date. I understand that continuation of the plan requires me to provide bank or credit card information in order to automatically draft the previously approved monthly membership fees.

**Benefit Waiver:**  REQUESTING TO WAIVE BENEFITS

Group Employee Signature (Required)

Date