

**SUBSCRIBER INFORMATION**

Please indicate your dental plan choice by marking the box with an "X"  Subscriber (Head of Household)  Subscriber +1  Subscriber +2 or More

Last Name	First Name	M.I.	Social Security Number	Date of Birth
Address	Apt.	City	State	Zip
Phone Number	Email	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Plan ID	Employer			

**SPOUSE**

Last Name	First Name	M.I.	Social Security Number	Date of Birth
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marriage Date	Does your spouse have other dental coverage? If yes, complete information below. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse's Employer Name		Effective Date		
Dental Insurance Name	Address	Phone Number	Policy #	

**DEPENDENTS**

Last Name	First name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Last Name	First Name	M.I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth

Are the dependents listed above covered under your spouse's dental insurance?  Yes  No  
 Are the dependents listed above covered under dental insurance, other than your spouse's?  Yes  No

**AVAILABLE PLAN OPTIONS**

NDB NEVADA KIDS SILVER + ADULT	SOUTHERN NEVADA RATES
Subscriber	\$16.90
Subscriber +1	\$33.80
Subscriber +2 or More	\$50.70

**PAYMENT METHOD**

I prefer to make:  One Time Annual (Payment in Full)  Recurring Monthly (1<sup>st</sup> of Month)  Monthly Payment Only

\*If no option is selected, we will automatically deduct payments on a monthly basis using your selected payment method. You may change this option at anytime by contacting Nevada Dental Benefits, Ltd. at 702-478-2014 or 866-998-3944

**CREDIT CARD PAYMENT**

Credit Card (tick one) <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMERICAN EXPRESS	Credit Card #	Security Code (CVV)	Expiration Date (MM/YY)
Amount \$	Billing Address	Billing Zip Code	

**ACH / ELECTRONIC CHECK PAYMENT** | Please attach a voided check

<input type="checkbox"/> Checking <input type="checkbox"/> Savings	Bank Name	Bank Routing Number
Bank Account Number	Amount \$	Account Holder's Name

**CHECK PAYMENT**

Please send your paper check along with this form to: **Nevada Dental Benefits, Ltd.** 6543 S. Las Vegas Blvd., 2nd Floor, Las Vegas, NV 89119

I hereby apply for coverage on the basis of the statements and answers to the questions above. I declare all answers to be true and complete. I understand that any incorrect statements made above may result in termination of coverage for my and/or dependent(s)' dental benefits. By my signature below, I acknowledge that Nevada Dental Benefits, Ltd. and its' authorized agents may use and disclose health information for purposes related to reviewing and processing my claims and my dependent(s)' claims, and authorize payment to Nevada Dental Benefits, Ltd. according to my preferred payment method.

Signature

Date mm/dd/yy

**Questions? Please call our customer care coordinators at 702-478-2014 or 866-998-3944 or email us at [contactus@nevadadentalbenefits.com](mailto:contactus@nevadadentalbenefits.com)**

For additional enrollees please use additional sheets\*