Nevada Dental Benefits, Ltd. ®
a PRIMECARE™ BENEFITS GROUP company

DENTAL PLAN ENROLLMENT FORM

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 ☐ Male ☐ Female		
Plan ID	Employer			

SPOUSE

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

DEPENDENTS

Last Name	First name	M.I.	Sex ☐ Male ☐ Female	Social Security Number	Date of Birth
Last Name	First Name	M.I.	Sex ☐ Male ☐ Female	Social Security Number	Date of Birth
Last Name	First Name	M.I.	Sex ☐ Male ☐ Female	Social Security Number	Date of Birth
Last Name	First Name	M.I.	Sex ☐ Male ☐ 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 (1st 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) ☐ VISA ☐ MasterCard ☐ DISCOVER ☐ 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

☐ Checking ☐ 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.*** PO BOX 81950, Las Vegas, NV 89180

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

*For additional enrollees please use additional sheets**