Dental Source Plan E Enrollment Form

Please complete this form by printing in ink or typing.
Note: All Members start on the 1st of the month.

Name _____ Social Security Number _____ - _____ - _____

Address _____ Employer _____

City _____ State _____ Zip Code _____ Marital Status o Married o Single _____ # of Dependents

Home Phone (_____) _____ Work Phone (_____) _____

I wish to cover the following eligible family members:

Name (Last, First, Initial)	Sex	Date of Birth
Enrollee _____	o M o F	____/____/____
Spouse _____	o M o F	____/____/____
Child _____	o M o F	____/____/____
Child _____	o M o F	____/____/____
Child _____	o M o F	____/____/____
Child _____	o M o F	____/____/____

IMPORTANT

Select a Dentist from the Dental Source Provider List

_____
Dentist Name

_____
Dental Source Provider ID#

Determine applicable monthly rate:

- o Subscriber Only .....$17 per month*
- o Subscriber plus 1 dependent .....$27 per month*
- o Subscriber plus family .....$39 per month*

1. I hereby apply for dental membership in the Plan E plan for myself and any eligible dependents listed.
2. I represent that the information provided is true and correct to the best of my knowledge.

Please Sign & Date This Form Here

Did You Remember To Select A Dentist In The Space Above? *

Signature: _____ Date: _____

Pay Monthly By Bank Draft

To pay your premiums monthly by automatic bank draft from your checking account please enclose a check with this application for the first month's premium plus the $15 enrollment fee. Also enclose a blank, voided check from the account we are to draft. Future premiums will be drafted from your account around the 15th day of each month.

Monthly Payment Premium Calculation:

o Monthly Billing - **BANK DRAFT OPTION ONLY** *$_____

One Time Enrollment Fee $15.00

Total amount due to enroll: $_____

For Bank Draft Payment Only

Sign this authorization and attach a voided check plus a check for the first month's premium plus the enrollment fee.

Bank Draft Authorization: I hereby request and authorize you to pay checks drawn on my account by FCL provided there are sufficient funds in said account to pay the same upon presentation. I understand that this authorization shall remain in effect until revoked by me in writing.

Signature: _____

Pay Annually By Check or Credit Card

To pay your premiums for a year in advance please enclose credit card information or a check with this application for twelve months of premium plus the $15 enrollment fee**. If premium was paid by credit card, future annual payments will not be automatically charged to your credit card upon renewal**. Approximately 30 days prior to your renewal date you will receive a notice.

Annual Payment Premium Calculation:

o Annual Billing ($_____* x 12) $_____

One Time Enrollment Fee $15.00

Total amount due to enroll: $_____

For Credit Card Payment Only

I authorize FCL Dental Plans to charge my credit card for payment of this dental plan premium.

Credit Card Number _____

Expiration Date _____ Signature _____

MasterCard, VISA, Discover, and American Express accepted.

For Office Use Only

Agent: _____

Dental Source is a dental prepaid plan licensed by the Missouri and Kansas Department of Insurance.

Make checks payable to FCL Dental Plans

Mail this form to:
FCL Dental Plans
101 Parklane Blvd., Suite 301
SUGAR LAND, TX 77478
Phone: (281) 313-7170 or 1-800-660-6064
Fax: (281) 313-7155

M-Plan E (04/21)