TDAHP Individual Dental Application

TDAHP
Total Dental Administrators Health Plan

Thank you for selecting TDAHP. ***Please print or type.***

Last Name (Contract Holder) First Name Middle Initial

Date of Birth (Month/Day/Year) Social Security Number

Street Address

c/o (if applicable) E-mail address (***required to receive plan documents and important plan notices***)

City State County ZIP Phone Number

Coverage Option A800R Pre-paid / DHMO Dental Plan

❑ **A800R Pre-paid / DHMO** — available only to residents of Arizona. ❑ Requested Effective Date: _____
All covered Pre-paid / DHMO services must be received in-network by a TDAHP contracted dental provider. *(First of the month effective dates only, please)*

This Section Must Be Completed:

Please select a DHMO General Dental Provider from the TDAHP provider listing. 5-Digit TDAHP General Dental Provider Number_____

Please visit **www.tdadental.com** to see TDAHP contracted dentists. TDAHP General Dental Provider Name _____

If you are applying for coverage to include more than one family member, list your spouse and/or dependent child(ren) up to the age of twenty-six (26) to be covered. Dependent children up to age 26 may be covered on the parent's policy regardless of their marital or student status. TDAHP requires one policy per child if purchasing "child only" coverage (*i.e.*, two children applying for "child only" coverage would require two applications). Coverage for dependent children will cease at the end of the month upon attainment of the limiting age of twenty-six (26).

Spouse's Last Name First Name Middle Initial Date of Birth (/ /) Social Security Number

If you need to include additional child dependents, please attach an additional sheet.

	Last Name	First Name	Middle Initial	Sex	Date of Birth	Relationship
1						
2						
3						
4						

For complete information on benefits, limitations, exclusions and emergency coverage, visit: www.tdadental.com/account/

AUTHORIZATION AND AGREEMENT: I agree to be bound by the terms and conditions of the TDAHP A800R Pre-paid / DHMO Individual Dental Plan and to remain enrolled in the plan for a minimum of one (1) calendar year. The Required Annual Premium may be paid in full or in convenient monthly installments. I acknowledge that I have read the Summary of Benefits, Limitations and Exclusions, and Emergency Procedures. I agree that in order to receive covered services provided by the TDAHP A800R Dental Plan, services must be obtained from a TDAHP Pre-paid / DHMO provider, except in emergencies. I understand that benefits and/or premiums are subject to change with 60 days' advance written notice from TDAHP.

Signature:_____ **Date:**_____

Broker Information: **CSA Broker Number:**_____

Internal Use Only
Date Processed_____ **Effective Date**_____ **Routed**_____

TDAHP
Total Dental Administrators Health Plan

TDAHP A800R PRE-PAID/DHMO INDIVIDUAL DENTAL PLAN APPLICATION

Thank you for choosing Total Dental Administrators Health Plan, Inc. (TDAHP, Inc.)
Please complete the entire application.

- Be sure to select your DHMO General Dental Provider from the directory at **www.tdadental.com**. Write the 5 digit General Dental Provider Number in the space provided on the application. If you have any questions about choosing your General Dental Provider or if you need assistance completing this application, please call your Broker or TDAHP's member services at (602) 266-1995 or toll free at (888) 422-1995. **Please Note: Only One Primary General Dental Provider per contract is allowed (contract includes all applicants and dependents).**
- You may change your Primary General Dental Provider selection at any time by notifying TDAHP by phone or in writing prior to the 25th day of the month. The change will be effective the 1st of the following month. If notification is received by TDAHP after the 25th day of the month, the change will be effective the month following next.
- To pay the required A800R annual premium through a convenient **monthly bank account checking withdrawal option,** attach a voided, blank check to this application and complete the "TDAHP Direct Payment Authorization" below. For annual payments, complete the "Credit or Debit Card Direct Payment Authorization" section below. You may also attach a check, money order, or cashier's check for the entire annual payment.
- Partial annual payments will not be accepted and returned to the sender.
- If your application is received by TDAHP prior to the 20th of month, the effective date of your A800R Pre-paid Dental Plan coverage will be the 1st of the following month. If received after the 20th, the effective date shall be the 1st of the month following next.
- Authorization to pay the required A800R annual premium either through monthly payments (EFT only) or annual Credit or Debit Card, Payment must be received by TDAHP prior to the 20th of the month for first of the following month activation.

A800R Pre-Paid /DHMO Plan—Premiums	Monthly Installment	Annual Premium
❑ Individual	$17.00	$204.00
❑ Individual + 1	$29.00	$348.00
❑ Individual + 2 or more	$45.00	$540.00

ELECTRONIC FUNDS TRANSFER

A convenient and affordable method of paying the required annual A800R premiums. Instead of one annual premium payment, we will deduct the required annual premium in monthly installments from your checking or savings account through a no hassle, electronic funds transfer.

To enroll in the monthly premium payment option, please complete the appropriate section below. Payments are deducted from your account on or about the 20th of each month preceding the month of coverage. (*e.g.*, February 20th payment, for March coverage month)

Please enclose a voided check for your first month's premium, which will initiate the set-up of your monthly electronic funds transfer.

TDAHP CREDIT OR DEBIT CARD DIRECT PAYMENT AUTHORIZATION FORM

I authorize TDAHP to initiate entries to debit my account for payment of plan premiums: ❑Monthly Installments ❑Annual
(Name on card if different:_____)
Card type: ❑ VISA ❑ Master Card ❑ Discover Card

Card #_____ Expiration Date:_____ ZIP:_____

Premium: $_____ Full Name:_____ Signature:_____

DIRECT PAYMENT AUTHORIZATION FORM (Monthly installment payments only)

I authorize TDAHP to initiate entries to debit my account for monthly premium installment payments. Please attach a voided, blank check.

This authority is to remain in force and effect for a minimum of one (1) year. Any request to terminate the Direct Payment Authorization must be received by TDAHP in writing. Any request to terminate your A800R Pre-paid DHMO plan coverage must be submitted to TDAHP in writing.

Signature:_____ Signature (optional for joint account):_____

Full name:_____ Full name:_____

Date:_____ Phone Number:_____ Date:_____ Phone Number:_____

Mail your Completed Application and Payment to:
Total Dental Administrators Health Plan, Inc. ♦ 2111 East Highland Avenue, Suite 250 ♦ Phoenix, Arizona 85016