SmartSmile℠ Enrollment Form

Step 1 » Your Information (All fields are required)

You can also enroll at smartsmile.com

Last Name | First Name | M.I.

Gender | Marital/Domestic Partnership Status | Employer

Preferred Spoken Language | Preferred Written Language

Address | City | State | Zip Code

Primary Phone ☐ Home ☐ Work ☐ Cell | Email | Birth Date

Requested Effective Date | Dentist Office Number

Additional Members / Dependents

Last Name	First Name	M.I.	Gender	Birth Date	Relationship to Subscriber

Dependents include your spouse, domestic partner and/or children under 26 years of age. Children 26 years of age and over are eligible only while the Child is and continues to be both 1) Incapable of sustaining employment by reason of developmental disability or physical challenge, and 2) Chiefly dependent upon the subscriber for support and maintenance, provided proof of incapacity and dependency is furnished to Dental Health Services within 31 days of the Child's attainment of the limiting age but not more frequently than annually after the two-year period following the child's attainment of 26 years of age.

Please return completed form to Dental Health Services at 100 W. Harrison St. Suite 440 South Tower Seattle, WA, 98119

Step 2 >> Choose Your SmartSmile℠ Plan

	SmartSmile℠	Monthly	Annually		Super SmartSmile℠	Monthly	Annually
☐	You	$19.15	$229.80	☐	You	$24.40	$292.80
☐	You & 1 dependent	$37.55	$450.60	☐	You & 1 dependent	$47.60	$571.20
☐	You & 2 dependents	$53.65	$643.80	☐	You & 2 dependents	$67.30	$807.60
☐	You & 3+ dependents	$77.00	$924.00	☐	You & 3+ dependents	$94.90	$1138.80

Step 3 >> Choose Your Payment Method and Include Payment

☐ Check or money order - annual payment
☐ Checking or Savings Withdrawal - automatic monthly payments
☐ Credit card - annual payment
☐ Credit card - automatic monthly payments
☐ Visa ☐ MasterCard ☐ Discover

Checking or Savings Account Number _____ Routing Number _____

Credit Card Number _____ Expiration _____

Amount (Annual or Monthly Premium) _____ 3-Digit Verification Code _____

By selecting a monthly payment option, you hereby authorize Dental Health Services to withdraw the applicable monthly invoice balance from your account. The account information on your enclosed check or listed credit card number will be the account from which your premium payment will be withdrawn monthly. Your monthly charge for subsequent months will be deducted between the 23rd and 28th day of the month prior to that month of service. For example, if you owe premium for February, your payment would be taken between the 23rd and 28th day of January. Monthly memberships renew automatically.

Cancellation requests must be received in writing and must be signed by the primary subscriber. Cancellation requests received by the 15th of the current month will be effective the first of the following month. You will receive a pro-rated refund if applicable.

By submitting this form, I authorize my dentist to release any information regarding my patient history to Dental Health Services, consulting professionals, or other designated or approved entities for the purpose of providing, evaluating, or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am over 18 years of age.
"It is a crime to knowingly provide false, incomplete, or misleading information to Dental Health Services for the purpose of defrauding Dental Health Services. Penalties include imprisonment, fines, and denial of insurance benefits."

Dental Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: If you, or anyone who is helping you has questions about Dental Health Services, you have the right to obtain information in your own language without any cost to you. To speak with an interpreter, call 1-866.756.4259.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Dental Health Services, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866.756.4259.

Chinese: 如果您或是您正在協助的對象，有關於[插入項目的 名稱 Dental Health Services 方面的問題，您有權免 費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 電話 插此數字 1-866.756.4259.

Signature _____ Date _____

And Now You're Done - Congratulations!

OFFICE USE ONLY

Eff. Date	A M Cycle	Group#	Plan#	P/S#	I.A.#	Producer Name	Producer#