Vantage Point | DENTAL PLANS APPLICATION

TDA Total Dental Administrators

☐ **Vantage Choice**
Co-Insurance Plan
TDA PPO Network
dentalCOMPANION

☐ **Vantage Care**
Co-Payment Plan
DHMO Network

DENTAL OFFICE CODE:
(Select a dental office from the list of participating providers)
_____

MINIMUM ENROLLMENT AGE IS 18, UNLESS ACCOMPANIED BY AN ADULT

First Name _____ Last Name _____ M.I. ____ Gender ☐ M ☐ F

Address _____ City _____

State _____ Zip Code _____ Birth Date (M/D/Y) _____ Social Security # _____

Phone (_____)_____ Email _____ Employer & City _____

Dependent:	First Name	Last Name	Sex	DOB	SSN
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					

VOIDED CHECK

VANTAGE CHOICE

Monthly

Single	$39.50
Two Party	$75.95
Family	$124.50

Monthly Rate Over 65

Single	$47.40
Two Party	$90.20
Family	$139.60

VANTAGE CARE

Monthly

Single	$18.85
Two Party	$37.65
Family	$60.80

APPLICATIONS ARE DUE ON THE 18TH OF THE MONTH PRIOR TO THE APPLICATIONS EFFECTIVE DATE.

VANTAGE POINT BENEFITS
231 East 400 South, Suite 370
Salt Lake City, UT 84111
FAX 801-983-8009
CONTACT US
PHONE 801-363-9577
WEB vpdental.com

VOIDED CHECK

Please select one of the following payment methods

Include a $10.00 one-time enrollment fee with your first payment

CHECKING OR SAVINGS ACCOUNT ☐ Checking ☐ Savings

Name of Bank or Credit Union _____

Transit / Routing Number _____

Account Number _____

CREDIT OR DEBIT CARD

☐ Visa ☐ MasterCard ☐ Discover Security code on back of card _____

Card # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration Date __ __ / __ __

Account Holder Name (PLEASE PRINT) _____

PLAN START DATE

1st day of _____ 20_____

AGENT USE ONLY

AGENT INFORMATION

Name _____
Phone _____
Agent # _____

☐ Monthly ☐ Annual (Premium x 12 months) Premium $ _____ + $10.00 (one-time enrollment fee)=$_____

I authorize Total Dental Administrators to debit my account, including the first months premium. I WISH TO ENROLL IN THE PLAN I HAVE SELECTED. By signing I agree to the terms and conditions outlined in the plan contract.

Signature (X) _____ Date _____

TDA Total Dental Administrators

Vantage Choice Plan Underwritten by Companion Life Insurance Company.

ALL PLANS ARE ONE YEAR CONTRACT

Opticare of Utah
1901 West Parkway Blvd., Salt Lake, City, UT 84119
800-363-0950 (www.opticareofutah.com)

APPLICATION FOR INDIVIDUAL VISION CARE INSURANCE POLICY

Please print all answers.

1. Owner (Applicant) – Owner is the Primary Insured		
(a)Owner Name (First/Middle/Last):		(b)Sex ☐ Male ☐ Female
(c)Date of Birth (Mo./Day/Yr):	(d)Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	(e)Social Security Number
(f)Home Address (Street, City, State, Zip Code):	(g) E-mail Address: (optional)	(h) Home Phone Number

2. Dependents (Indicate the names of all dependents to be insured under the policy.)

Name	SS#	Date of Birth	Name	SS#	Date of Birth
Spouse:			Child:		
Child:			Child:		
Child:			Child:		

3. Benefit Selection
Vision Plan Selected ☐ 15-150B ☐ 10-150

4. Premium Payment

Premium Payment Mode ☐ Monthly ☐ Annually	Banking	**Amount of Premium Payment Enclosed** $
Payment Choice (Select one) ☐ Checking Account (enclose voided check) ☐ Savings Account (enclose savings slip) ☐ Credit Card (Only if paying Annually)	**Account Number** **Routing Number**	**Credit Card Number** **EX Date:** **CCV:**
Financial Institution Name:		

5. Representations – Owner Agreement

I agree that: (1) the statement and answers given in this application are true, and correctly recorded to the best of my knowledge and belief; (2) this application will be part of the contract for which I apply; (3) the policy is a one year contract that is guaranteed renewable in accordance with the terms of the policy; (4) I understand that this policy must remain in force for a 12-month period and that premiums are due for the entire 12 month period; (5) I understand that this policy will be renewed on each policy anniversary date for a new 12-month period unless given written notification to Opticare of Utah to terminate the policy 60 days prior to the policy renewal date. I will notify the insurer if any statements or answers given in this application change prior to policy deliver; and (6) I have received the outline of coverage.

I herby authorize Opticare of Utah to withdraw premium payments from the financial institution and account named above under section 4 of this application. I understand that this authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdraw by notifying the financial institution at least three business days before the withdraw is made. In the event of a withdraw error, I must promptly notify the financial institution to preserve any rights I may have. I understand that I may direct my billing inquiries to Opticare of Utah, 1901 West Parkway Blvd, Salt Lake City Utah 84119.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information the insurer requests.

Any person who knowingly presents a false of fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

The policy provides vision benefits only. Review your policy carefully.

Signature of Owner (Primary Insured) _____ Date signed _____

State in which Policy will be Delivered _____ State in which Owner Signed Application _____

Printed Name of Licensed Insurance Agent _____ Signature of Licensed Insurance Agent _____ Agent License Number _____