

Vision Monthly Rates

	Signature Choice	Exam Plus
Member	\$8.99	\$3.00
Member + 1	\$18.00	\$6.00
Member + Family	\$28.99	\$9.00

Application Step 1

Benefits Association Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<p>"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthly membership fee is \$1.00 and is included in the monthly rates."</p> <p>Member Signature:</p> <p>_____</p> <p>Date _____</p>
Home Phone	Street					
	City	State		Zip		

For additional information email MorganWhiteGroup at marketing@morganwhite.com or call 1-800-800-1397

Sign Here

Application Step 2 Dental For Everyone Enrollment Card

Plan Selection: <input type="checkbox"/> Platinum Plan <input type="checkbox"/> Gold Plan Network Selection: <input type="checkbox"/> Delta Dental Premier® <input type="checkbox"/> Delta Dental PPO Type of Coverage <input type="checkbox"/> Member <input type="checkbox"/> Member + 1 <input type="checkbox"/> Member + Family Optional Vision Coverage: <input type="checkbox"/> Exam Plus <input type="checkbox"/> Signature Choice					METHOD OF PAYMENT <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Bankdraft: This is my authorization for Morgan-White Administrators, Inc., on behalf of Delta Dental Insurance Company to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn. Name of Bank: _____ Name as it appears on Check: _____ Routing Number (Bottom Left Corner of Check) _____ Account Number (2nd set of numbers on bottom) _____ <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____ Exp. Date ____/____/____ Security Code _____ (3 digit code on back of card)	
Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Home Phone	Street					
	City	State		Zip		
	E-mail address:					
LIST ALL DEPENDENTS TO BE COVERED BELOW						
Last Name (if different)		First Name	Initial	Birthdate	Sex	
2. Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	
3. Dependents					<input type="checkbox"/> M <input type="checkbox"/> F	
4.					<input type="checkbox"/> M <input type="checkbox"/> F	
5.					<input type="checkbox"/> M <input type="checkbox"/> F	
6.					<input type="checkbox"/> M <input type="checkbox"/> F	
7.					<input type="checkbox"/> M <input type="checkbox"/> F	
<p>"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been accepted and approved by Delta Dental Insurance Company and (2) the agent does not have the authority to make or alter any contract or waive any of Delta Dental's other rights or requirements."</p> <p>Association Member's Signature _____ Date _____</p>						

For Agent Use Only AGENT NAME (if applicable): _____

AGENT # (Your state license #): _____