

IBC CHOICE DENTAL PLAN ENROLLMENT APPLICATION



45 East Milwaukee
Detroit, MI 48202

Phone: 313-972-1400
Fax: 313-972-4662

www.ibcchoicedental.com

LAST NAME	FIRST	M.I.	DATE OF BIRTH			SEX		SOCIAL SECURITY NUMBER
			MO	DAY	YEAR	M	F	
STREET ADDRESS		APT. #		PROVIDER LOCATION SELECTED				
CITY	STATE	ZIP		#				
HOME PHONE			EMAIL (OPTIONAL)			EMPLOYER		

	LIST ALL DEPENDENTS TO BE COVERED BELOW INCLUDE LAST NAME IF DIFFERENT FROM SUBSCRIBER	DATE OF BIRTH			SEX		SOCIAL SECURITY NUMBER
		MO	DAY	YEAR	M	F	
SPOUSE							- -
CHILD ONE							- -
CHILD TWO							- -

SIGNATURE _____ DATE _____ EFFECTIVE DATE _____

IBC CHOICE DENTAL PLAN Enrollment Application continued ...



Annual Coverage Costs:

Single: \$110.00
Two Persons: \$170.00
Family: \$250.00

Single Two Persons Family

TOTAL ENCLOSED AMOUNT = \$ _____

Please make check or money order payable to: Individual Benefits Company

Mail to: Individual Benefits Company (IBC)
45 E. Milwaukee Ave., Detroit, MI 48202

CREDIT CARD PAYMENT

American Express Discover MasterCard Visa

CARD HOLDER'S NAME (PLEASE PRINT) _____

CREDIT CARD NUMBER _____

EXPIRATION DATE _____

I understand that I am responsible for the co-payments on all services received as specified in the Schedule of Benefits and Co-payments and for full payment of all other non-covered dental services. I also understand refunds are not issued after thirty (30) days of enrollment or after the use of the plan.

Signature Required _____

Date _____

REFERRED BY (if applicable) _____

PRINT AGENT / BROKER NAME _____

AGENT / BROKER PHONE NO. _____ AGENT NO. _____

