Alpha Dental Plan Membership Application

When submitting the membership application I understand and agree:

1. The administrative and billing fee is to be included in draft amount.
2. **I hereby agree to remain in the Alpha Dental Plan a minimum of one year.** Less than one year membership may result in my being billed from the Alpha Dental Plan provider the usual customary rates for dental services provided, minus payments for services rendered during the year.
3. That benefits from Alpha Dental Plan are available through the offices of participating providers only. I am aware that Dental Specialists are not available in all areas, and this is a Discount Fee for Service Plan.
4. I will make all scheduled payments to the Alpha Dental Plan provider at the time services are rendered. I know this is NOT insurance.
5. I have received a copy of all covered services, payment schedule, and exclusions offered by the Alpha Dental Plan.
6. I hold the Alpha Dental Plan blameless for any harm or loss arising from services or omission of services by the providing dentist and his staff.
7. Beta Health Association is the Administrator for the Alpha Dental Plan.
8. To cancel I must notify Beta Health in writing 30 days in advance and will be responsible for any insufficient charges.

X_____
Signature of Applicant Date

PLEASE NOTE: If more than one person is enrolled, they must be members of the same household. Your Alpha Dental Plan cost is only $11.00 per month for one member, $21.00 for two family members, and 31.00 for three or more family members.
Application must be received in the Alpha Dental Plan office by the 25th of the month to be effective the first of the following month.

YOU DO NOT NEED TO WAIT FOR YOUR I.D. CARD TO GO TO A DENTIST. YOUR DENTIST WILL RECEIVE AN ELIGIBILTY LIST ON THE FIRST OF THE MONTH.

HOW TO JOIN

1. Fill out and sign the attached application. Choose billing method
2. Select the dental facility you wish to visit from the online list.
3. Your bank draft is processed on the 15th of the month for the following month's coverage. Your 1st draft will begin on the 2nd month of your coverage.
4. You may pay quarterly or annual payments plus a $20.00 annual fee. Enrollment application and payment should be directed to:

Alpha Dental Plan
609 E. Speer Blvd. Suite 200
Denver, CO 80203
303-744-3007 - 800-807-0706

Please note: If your Employer would offer the plan to the company and provide a payroll deduction, you would save the $20.00 annual fee. Call Alpha if your employer is interested.

MONTHLY AUTOPMATIC WITHDRAWAL FROM CHECKING OR SAVINGS.
Please attach a copy of a void check or deposit slip. Cannot process application without this. Check box below for your billing.

One Person ☐ $11.00	1. Alpha Dental Plan Cost (1st Mo.) $_____
Two Persons ☐ $21.00	2. Alpha Dental Plan Cost (Last Mo.) $_____
Three Or More ☐ $ 31.00	3. Beat Health Monthly Admin. Fee $__4.00 (2 mo.)___
	4. **Total Enclosed** $_____
	* Must include SS# on Reverse Side

***ANNUAL PAYMENT METHOD** (check/credit card/money order) Payable To: Beta Health Association	* Annual Payment $_____
	Annual Admin Fee $ 20.00 (paid annually)
	For Seniors over 60 Pay $10.00 $ 10.00 (paid annually)
	Total Enclosed $_____
Total Enclosed $_____	
One Person ☐ $127	CC#_____
Two Persons ☐ $247	Expiration Date: _____
Three Or More ☐ $367	Signature _____
Save $10 Annually	

** QUARTERLY PAYMENT METHOD	1. Alpha Dental Plan Cost $_____
One Person ☐ $34.25	2. Beta Health Administrative Fee (T.P.A.) $ 20.00 (paid annually)
Two Persons ☐ $65.25	3. Seniors Over 60 Pay $10.00 $ 10.00 (paid annually)
Three Or More ☐ $ 94.25	**Total Enclosed** $_____
$1.25 billing fee will be added per statement.	

COMPLETE THIS FORM TO JOIN ALPHA DENTAL PLAN OF COLORADO INC.

SOCIAL SECURITY NO.	LAST NAME	FIRST	INTIAL	BIRTH DATE MO. DAY YR.	HOME PHONE
				MALE ☐ FEMALE ☐	WORK PHONE
HOME ADDRESS				State / ZIP CODE	DENTAL OFFICE SELECTED
NAME AND ADDRESS OF EMPLOYER OR ORGANIZATION				AGENT # **707**	MARITAL STATUS ☐ Married ☐ Single ☐ Widowed ☐ Divorced
				DESIRED EFFECTIVE DATE: Coverage begins first month only.	Do you have dependants? ☐ Yes ☐ No

List all the dependents below that you wish to enroll.

Last Name (if different)	First Name	Initial	Sex	Birth date
Spouse				
Child				
Child				
Child				
Child				

PLEASE NOTE:
Enrollments must be signed and received by the 25th of the month for a 1st of the month effective.

Beta Health Association, 609 E. Speer Blvd., Suite #200, Denver, CO 80203