

MARS Associates Plan Options:

- Low Option* - Delta Dental Patient Direct® Plan # 9000
- Medium Option - Exclusive Panel Option (EPO) Plan # 9001
- High Option - Delta Dental PPOSM Plan # 9002

***NOTE:** The Patient Direct plan requires members to select a dentist from the enclosed list. Please indicate:

Dentist Name: _____

Patient Direct

Provider Number: _____

Subscriber Information (Complete for all enrollments/changes/updates) Male Female

Subscriber Name (Last) (First) (Middle Initial)

Subscriber Social Security Number Subscriber Date of Birth (MM-DD-YYYY)

Mailing Address

City State Zip Code

Phone Number Date of Retirement (MM-YYYY)

Dependent Information (For additional dependents, please attach an additional sheet.)

Dependent 1 Name (Last) (First) (Middle Initial)

Dependent - 1 Birth Date (MM-DD-YYYY) What is Dependent 1's relationship to the retiree?

Dependent 2 Name (Last) (First) (Middle Initial)

Dependent 2 Birth Date (MM-DD-YYYY) What is Dependent 2's relationship to the retiree?

Dependent 3 Name (Last) (First) (Middle Initial)


Dependent 3 Birth Date (MM-DD-YYYY) What is Dependent 3's relationship to the retiree?

Premium Payment Method

Complete both sides of this form and choose one of the payment options listed below. Return the completed application in the enclosed envelope to Delta Dental of Colorado.

Select a payment option:

- Bank Account Debit** - Your payment will be deducted automatically from your bank account on the fifth of each month. Please complete the Authorization for Automatic Premium Payment (APP) on the back side of this form. Please include a voided check with your application.
- Credit Card** - Payments will be automatically charged to your credit card on the 1st of each month. Please complete the Authorization for Automatic Premium Payment (APP) on the other side of this form.

 Please complete the back of the form too!

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Subscriber Name (Last) (First) (Middle Initial)

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Subscriber Phone Number (including area code)

Bank Account Debit

Account Type: Checking Savings

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Name on Account

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Name of Bank

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Routing Number (first nine digits on check)

Account Number

Credit Card

Account Type: MasterCard Visa

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Cardholder's Name

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Credit Card Number

Expiration (MM/YY)

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Address

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City

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State

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Zip Code

Automatic Premium Payment (APP) Agreement

I hereby authorize Delta Dental of Colorado to initiate debit entries to my checking or savings account or to charge my credit card, as indicated. If the amount of entry differs from the previous month's entry initiated pursuant to this agreement, Delta Dental of Colorado shall notify me in writing of the new amount not less than ten (10) calendar days prior to debiting my account.

This authorization is to remain in full force and effect until Delta Dental of Colorado receives thirty (30) days written notice from me of its cancellation. The notification must be sent to Delta Dental of Colorado, PO Box 5468, Denver, CO 80217-5468.

If my account is erroneously debited by Delta Dental of Colorado, I have the right to request that my financial institution credit the amount in question to my account within 15 calendar days. In this instance, I will notify my financial institution in writing regarding the error, and request a credit to my account for the amount in question.

IMPORTANT: You MUST attach a voided check if you are authorizing checking/savings account debit. Keep a copy of this agreement for your records.

Signature of Authorized Account Holder

Date