

United Dental Care of Texas, Inc. Application Form

Please retain a copy of this application for your records

AGENT NUMBER

4UD3115-M

Your Social Security Number	Last Name	First Name	Middle Initial	Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Your Date of Birth	Address		Write the Dental facility Number of the dentist(s) you choose from the directory in this space(s) below.		
Home Phone	City	State	Zip		

List Dependents to be Enrolled		Relationship	Date of Birth	Sex
First Name	Middle Initial	Last Name (if different)		
Spouse				M <input type="checkbox"/> F <input type="checkbox"/>
Child				M <input type="checkbox"/> F <input type="checkbox"/>
Child				M <input type="checkbox"/> F <input type="checkbox"/>

Attach a separate sheet of paper for additional children.

Check this box if you have a disability affecting your ability to communicate or read. Please include your primary language by placing a check in the appropriate box. English Spanish Other _____

Prepayment Fee Amount	\$ _____ +	<input type="checkbox"/> Annual Payment - make the check payable to United Dental Care of Texas, Inc.	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover
Enrollment Fee	\$ 20.00	<input type="checkbox"/> Charge my annual prepayment fees	Exp. Date Mo. _____ Yr. _____
Total Enclosed	\$ _____	<input type="checkbox"/> Automatic Monthly Bank Draft - complete the Authorization Agreement on the reverse side of this form.	

By my signature below, I understand that a full description of this Individual HMO Dental Plan will be provided in the Individual Dental Service Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to United Dental Care of Texas, Inc., Union Security Insurance Company and their affiliated dental companies my dental records, photocopies or information regarding such procedures to the extent permitted by law. It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of benefits. This authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing United Dental Care of Texas, Inc., Union Security Insurance Company and their affiliated dental companies to use and disclose protected health information.

Agent's Signature _____ **Date** _____ **Subscriber's Signature** _____ **Date** _____
 10.86 17.51 26.89 This is an important document that will become part of your contract. Benefits administered by Union
 115.28 195.10 307.72 Security Insurance Company and provided by United Dental Care of Texas, Inc..
 BDC-IAPP-TX

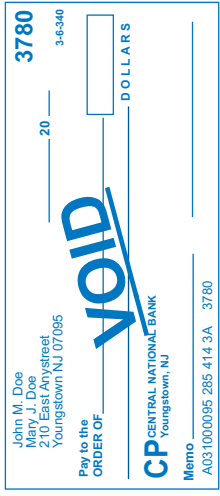
Authorization Agreement For Automatic Monthly Bank Draft

Name(s)		Social Security Number		Checking <input type="checkbox"/>		Savings <input type="checkbox"/>	
<p>I (we) hereby authorize United Dental Care of Texas, Inc. to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.</p>							
Bank Name		City		State			
<p>Include Your Checking or Savings Account Number in the Boxes Below:</p>							
Account Number							

IMPORTANT

If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's pre-payment fee and \$20 enrollment fee with this form and send them to us.

Prepayment fees are deducted from your authorized account on the 15th of the month prior to the month of benefits. The Authorization Agreement automatically renews if the Individual Dental Service Agreement renews.



This authorization is to remain in full force and effective until United Dental Care of Texas, Inc. has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature _____ **Date** _____

United Dental Care of Texas, Inc.
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 Birmingham, AL 35243
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