

**Questions? Call us at CDA Insurance: 1-800-884-2343 or 541-434-9613**

## ***ODS Dental Application***

### **Tips for completing the application :**

Please read everything carefully and answer all questions honestly. This document becomes part of your dental insurance contract. Use a Black or Blue ink Pen.

**Payment:** The payment options are monthly, or quarterly. Auto-draft is available.

- Please complete carefully and attach a voided check.
- Simply check the corresponding box and you are done

### **Final check list before mailing:**

- A Check to ODS for the first premium.
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal

### **Mail Completed Application to:**

CDA Insurance LLC  
PO Box 26540  
Eugene, Oregon 97402

### **Fax application and payment:**

If you prefer faxing your application and payment in, you can do that too!  
Complete the application and fax it along with a voided check to:

**Fax# - 541.284.2994**



# ODS Individual Dental Enrollment Application

Please complete both sides of this form and sign on the back. Please type or print legibly in dark blue or black ink.

Applicant Name (First, MI, Last)	Birthdate	Gender	Applicant Social Security No.
Applicant Mailing Address	City	State	ZIP
Choose A Plan			Home Telephone No.
<input type="checkbox"/> Premier Plan <input type="checkbox"/> Preferred Provider Option (PPO) Plan			

1. Are you a resident of Oregon?  Yes  No  
*(In order to be eligible to enroll in this plan, you must be an Oregon resident and live in Oregon for at least six (6) months out of the year.)*

2. Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage?  Yes  No  
 If yes, please provide the following:

- OR [ 1. Name of individual enrolled in prior plan: \_\_\_\_\_  
 2. Carrier name: \_\_\_\_\_ Carrier telephone number: \_\_\_\_\_  
 Effective: \_\_\_ / \_\_\_ / \_\_\_ Termed: \_\_\_ / \_\_\_ / \_\_\_  
 3. Copy of prior dental plan ID card, front and back.

## Dependent Information

Name (First, MI, Last)	Birthdate	Gender	Social Security No.
Spouse/Registered Partner*		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F	

\*Registered partner according to the Oregon Family Fairness Act.

### Type of Application

New Enrollment

This application for dental insurance coverage is for:

Insured Only

Insured + Spouse or registered domestic partner\*

Family

Insured + Child(ren)

### Individual Dental Eligibility Requirements

You are eligible for individual dental coverage under this agreement if you meet the following requirements:

- You are an Oregon resident and live in Oregon at least six months out of the year.
- If you terminate this coverage you will be required to wait one year before you may re-apply with a maximum of two re-applications per member per lifetime on either plan.
- Any new enrollment will begin at the first-year benefit level.

**ODS Enrollment Application** *It is very important that you sign and date below.*

**Billing Information: Choose One Option**

**Option 1: Auto Pay Plan (checking account deduction)**

Bank Name: \_\_\_\_\_ Branch: \_\_\_\_\_  
Bank Address: \_\_\_\_\_ Bank Account No.: \_\_\_\_\_

This authority is to remain in full force and effect until ODS and my bank have received written notifications from me of its termination in such time and in such manner as to afford ODS and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such an error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

- Attach a check for one month's premium made payable to Oregon Dental Service, or indicate here if you want the initial premium drafted.  Yes  No
- Attach a "voided" check from which you want the payment withdrawn.
- Funds will transfer on or around the fifth calendar day of each month.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Option 2: Monthly Billing Statement**

- A \$5 monthly administration fee is required with this payment method.
- Attach a check or money order for one month's premium made payable to Oregon Dental Service. A bill will be sent in the mail every month.

**Option 3: Quarterly Billing Statement**

- A \$5 quarterly administration fee is required with this payment method.
- Attach a check or money order for three months' premium made payable to Oregon Dental Service.

**For Agent Use Only — Reminder: Collect Premium with Application**

I, (the Agent) certify I have explained the eligibility provisions to the Applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by ODS, and provided Oregon Disclosure Information required. I CERTIFY THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name (please print or type): Dann Loewenthal

Agency Name: CDA Insurance LLC

Telephone No.: 1.800.884.2343

Street Address: 2160 W 11th Ave Suite D

City: Eugene

State: OR

ZIP: 97402

Agent Signature (required): \_\_\_\_\_

Date: \_\_\_\_\_

**Applicant Signature**

I understand mailing a check to ODS does not guarantee coverage. The effective date of coverage will be the 1st of the month following the receipt of my application if eligibility is met. If my application does not otherwise meet the eligibility requirements as stipulated, ODS will notify me in writing and my payment will be returned.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(or signature of minor's representative for any applicant under age 18)

Insurance products provided by Oregon Dental Service  
ODS ELIGIBILITY DEPARTMENT • 601 S.W. SECOND AVENUE • PORTLAND, OR 97204  
503-265-5696 • 800-852-5195 x5696 • www.odscompanies.com