Vision Monthly Rates

	Signature Choice	Exam Plus
Member	$8.99	$3.00
Member + 1	$18.00	$6.00
Member + Family	$28.99	$9.00

Application Step 1

Benefits Association Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee: Last Name / First / Initial	Birthdate	Sex ❑ M ❑ F
Home Phone	Street		
	City / State / Zip		

"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthy membership fee is $1.00 and is included in the monthly rates."

Member Signature:

_____

Date _____

Sign Here

For additional information email MorganWhiteGroup at **marketing@morganwhite.com** or call **1-800-800-1397**

Application Step 2 Dental For Everyone Enrollment Card

Plan Selection: ❑ **Platinum Plan** ❑ **Gold Plan**
Network Selection: ❑ **Delta Dental Premier®** ❑ **Delta Dental PPO**
Type of Coverage ❑ **Member** ❑ **Member + 1** ❑ **Member + Family**
Optional Vision Coverage: ❑ **Exam Plus** ❑ **Signature Choice**

Social Security No.	Primary Enrollee: Last Name / First / Initial	Birthdate	Sex ❑ M ❑ F
Home Phone	Street		
	City / State / Zip		
	E-mail address:		

LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different) / First Name / Initial	Birthdate	Sex
2. Spouse		❑ M ❑ F
3. Dependents		❑ M ❑ F
4.		❑ M ❑ F
5.		❑ M ❑ F
6.		❑ M ❑ F
7.		❑ M ❑ F

METHOD OF PAYMENT

❑ Annually ❑ Quarterly ❑ Monthly

❑ Bankdraft: This is my authorization for Morgan-White Administrators, Inc., on behalf of Delta Dental Insurance Company to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn.

Name of Bank:

_____

Name as it appears on Check:

_____

Routing Number (Bottom Left Corner of Check)

_____

Account Number (2nd set of numbers on bottom)

_____

❑ Visa ❑ Mastercard
Credit Card #:

_____

Exp. Date _____/_____

Security Code _____
(3 digit code on back of card)

"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been aceepted and approved by Delta Dental Insurance Company and (2) the agent does not have the authority to make or alter any contract or waive any of Delta Dental's other rights or requirements."

Association Member's Signature _____ Date _____

For Agent Use Only

AGENT NAME (if applicable): _____

AGENT # (Your state license #): _____