

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: PacifiCare

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...

PacifiCare[®]
A UnitedHealthcare Company

Benefit & Copayment Highlights



Preventive Services

	Member Pays:
Office visit	No Charge
X-rays, full mouth.....	No Charge
Single film	No Charge
Each additional film	No Charge
Teeth cleaning	No Charge
Topical fluoride (under age 18)	No Charge
Sealants (per tooth; under age 18)	Not Covered
Diagnostic casts (non-orthodontic)	\$ 10.00
Emergency treatment (palliative)	\$ 10.00
Office visit (after-hours)	\$ 20.00

Routine Services

Restorative Dentistry

	Member Pays:
Amalgam restorations (cavities involving permanent teeth)	
One tooth surface	\$ 15.00
Two tooth surfaces	\$ 20.00
Three tooth surfaces	\$ 26.00
Resin restorations, per tooth (anterior)	\$ 25.00
As above, involving incisal edge.....	\$ 28.00
Resin restoration (posterior)	\$66.00-\$1 02.00
Pin retention in addition to final restoration, per tooth	\$ 5.00
Sedative base	\$ 7.00

Oral Surgery

Extraction (uncomplicated).....	\$ 16.00
Each additional tooth (same visit)	\$ 10.00
Soft tissue impaction	\$ 50.00
Partially bony impaction	Not Covered
Completely bony impaction	Not Covered
Biopsy of oral tissue (soft)	\$ 10.00
Biopsy of oral tissue (hard)	\$ 16.00
Surgical removal of an erupted tooth	\$ 40.00
Alveoplasty (not in conjunction with extractions), per quadrant	\$ 80.00
Alveoplasty in addition to tooth extraction, per quadrant	\$ 90.00
Drain abscess/intraoral	\$ 30.00
Drain abscess/extraoral	\$ 30.00
Frenectomy.....	\$ 50.00

Endodontics

Pulp capping (direct)	\$ 10.00
Pulp capping (indirect)	\$ 24.00
Therapeutic pulpotomy.....	\$ 22.00
Root canals - Anterior	\$100.00
Root canals - Bicuspid.....	\$130.00
Root canals - Molar	\$1 75.00
Prefabricated post	\$ 50.00
Cast post and core	\$ 65.00

Periodontics

Gingival curettage, per quadrant	\$ 40.00
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Major Services

	Member Pays:
Crowns and pontics	
Stainless steel, primary tooth	\$ 30.00
Resin crown †	\$ 85.00
Full metal crown*	\$145.00
3/4 metal crown*	\$140.00
Porcelain crown †	\$130.00
Porcelain with metal crown* †	\$165.00
Cast post and core, in addition to crown*	\$ 65.00
Pontic, cast metal (base)	\$145.00
Pontic, porcelain with metal*	\$165.00
Inlay recementation	\$ 12.00
Crown recementation	\$ 12.00
Bridge recementation	\$ 18.00

Prosthetics

Denture adjustment	\$ 12.00
Replace tooth, per tooth	\$ 23.00
Denture repair	\$ 28.00
Denture reline (office)	\$ 35.00
Denture reline, lab-processed	\$ 65.00
Interim partial denture	\$ 60.00
Partial denture, upper or lower (including any conventional clasps, rests, and teeth)*.....	\$225.00
Partial denture (cast metal base with resin saddle), upper or lower (including any conventional clasps, rests, and teeth)*	\$255.00
Complete denture, upper or lower	\$250.00
Add tooth or clasp to existing partial.....	\$ 31.00
Fixed space maintainer	\$ 55.00
Removable acrylic space maintainer	No Charge
Clasps, each additional, for space maintainer	No Charge

* plus actual lab cost of gold. † not for molars.

Dentist may charge \$20.00 for broken appointments if not notified at least 24 hours in advance.

Orthodontics

Class I (teeth straightening)	\$1,895.00
Class II (correction of overbite)	\$1,895.00
Class III (correction of underbite)	\$1,895.00

Specific copayment levels have also been set for startup and retention services. The orthodontic benefit covers: consultation, retention, banding, and monthly office visits for 24 months.

Orthodontic treatment must be provided by a PacifiCare Dental Panel Orthodontist. A referral must be submitted by the assigned general dentist, and an orthodontist will be assigned by PacifiCare Dental.

Refer to the *Evidence of Coverage and Disclosure Form* booklet and the *Orthodontic Information Sheet* for complete details of benefits, exclusions, limitations, and plan description. There is no specialty referral for the Dental 160 plan. Copayments are applicable at participating general dentist offices only.

PacifiCare[®]
Dental

Dental 160 Plan Individual Member Enrollment



INSTRUCTIONS FOR COMPLETING ENROLLMENT FORM

- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Subscriber:** Fill out section completely. **Remember to indicate the Provider Group Number/Dentist/City you have selected.**
- **Dependents:** All dependents you wish to be covered should be listed in this section with their selected **Provider Group.**
Don't forget to indicate their **Provider Group Number/Dentist/City selections.**
- **Method of Payment:** Please indicate your preferred method of payment, Monthly Auto Pay or Annual Payment. Should you choose the Monthly Auto Pay option, complete and sign the Pre-Authorized Payment Application on the adjacent page. PacifiCare Dental will then automatically deduct the monthly premium from your checking account. Or, if you select the Annual Payment option, please include a check made payable to PacifiCare Dental for the annual premium and one-time enrollment and processing fee of \$15.00.
- **Terms and Conditions:** Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of the sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

Cut here

SUBSCRIBER (You)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name		First Name		MI	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number		Home Phone { }
Mailing Address		City	State	ZIP	Work Phone { }
Provider Group Number		Dentist's Name/City		Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEPENDENTS (Your spouse and/or children)

1	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number
	Provider Group Number		Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number
	Provider Group Number		Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number
	Provider Group Number		Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No
4	Relationship (spouse, daughter, son)	Last Name	First Name	MI
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Social Security Number
	Provider Group Number		Dentist's Name/City	Have you received treatment from this dental office? <input type="checkbox"/> Yes <input type="checkbox"/> No

METHOD OF PAYMENT

Monthly Auto Pay

Complete the attached **Pre-Authorized Payment Application** and include a **voided check**. A one-time non-refundable enrollment and processing fee of \$15.00 will be debited from your checking account along with your first month's premium.

or save when you select the Annual Payment Option...

Annual Payment

Include a check payable to **PacifiCare Dental** for your annual premium. In addition to the annual premium amount, please include a one-time non-refundable enrollment and processing fee of \$15.00.



I understand and agree to the terms and conditions on the adjacent page.

X

Enrollee Signature

Date

Agent: ERIC TAPIA Agent #7439985 Office (888)599-7056 Return Fax: 909-599-7008

Mail to:

Attn: LC05-232
PacifiCare Dental
Post Office Box 25187
Santa Ana, CA 92799-5187

Tel 1-800-228-3384 or
1-800-22-TEETH
Fax (714) 513-6397 or
(714) 513-6507



- Remember to select a provider!
- Be sure to read the terms and conditions below and sign in the box at the "X."

TERMS AND CONDITIONS (Please read and sign on adjacent page)

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than \$5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than \$5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in PacifiCare Dental both member (including any heirs or assigns) and PacifiCare entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage.

PRE-AUTHORIZED PAYMENT APPLICATION

Complete this section only if you want your monthly premium automatically deducted from your checking account.

Our Pre-Authorized Payment Plan

It's the forget-proof method of paying your premium — almost as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no more paperwork for you and no more checks to write. No worries about monthly late-payment charges. And you'll save on postage and envelopes. It's easy, reliable, and automatic.

Authorized Agreement for Pre-Arranged Payments (Debits)

I (we) hereby authorize PACIFICARE DENTAL to initiate debit entries to my (our) checking account indicated below, and the bank named below, herein called BANK, to debit the same to such account.

Account No. (please enclose one voided check) _____

Bank Name _____ Bank Phone _____

Street Address _____

City _____ State _____ ZIP _____

This authority is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name (print clearly) _____ Social Security No. _____

Signature _____ Date _____



AGENT AND BROKER USE ONLY

Agent Name	Agent Number	Agent Phone ()
Agent Address	City	State ZIP