# INDIVIDUAL ENROLLMENT FORM

BrightIdea DENTAL | BrightIdea VISION | MyHealthPass Feel Better Faster

**Eff Date:**_____ ☐ **New Enrollee** ☐ **Change To Existing:**_____

**Primary Member Name:**

First Name Last Name

SSN:_____ DOB:_____ Gender: ☐ M ☐ F

Mailing Address:_____

Address City State Zip

Phone #: ( ) Email:

**Dependent Information** (if applicable)

**Spouse:**_____ **SSN:**_____ **DOB:**_____ **Gender:** ☐ **M** ☐ **F**

First Name Last Name

Child:_____ SSN:_____ DOB:_____ Gender: ☐ M ☐ F

First Name Last Name

Child:_____ SSN:_____ DOB:_____ Gender: ☐ M ☐ F

First Name Last Name

Child:_____ SSN:_____ DOB:_____ Gender: ☐ M ☐ F

First Name Last Name

Child:_____ SSN:_____ DOB:_____ Gender: ☐ M ☐ F

First Name Last Name

Child:_____ SSN:_____ DOB:_____ Gender: ☐ M ☐ F

First Name Last Name

**Benefit Elections**

| Eff Date | Plans | Coverage Level | | | | Monthly Fees/Premium |
|---|---|---|---|---|---|---|
| | | Indiv | Indiv+S | Indiv+C | FM | |
| | **Dental:** ☐ **Choice Plan** ☐ **Premier Plan** | ☐ | ☐ | ☐ | ☐ | $ |
| | **Vision** ☐ | ☐ | ☐ | ☐ | ☐ | $ |
| | **MyHealthPass** ☐ | ☐ | ☐ | ☐ | ☐ | $ |
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| | **Total Monthly Fees/Premium:** | | | | | $ |

**Credit/Debit Card/ACH Informaton** **Monthly Deduction will be taken on:** ☐ **5th** ☐ **10th** ☐ **15th**

**Name on CC/Debit Card:**_____ Card #:____-____-____-____ Exp. Date:____/_____ CVV Code:_____

**Billing Address if different that address above:**

**Name on Checking Account:**_____ Routing #:_____ Account #:_____

**Address on account if different than address above:**

I authorize the monthly fees/premium for the benefits that I have elected to be deducted from the credit/debit card or bank acccount shown above. The deduction will be taken from my credit/debit card or bank account the month prior to coverage.
I understand that a $25 fee will be charged to me for declined credit/debit card transactions or for ACH non sufficient funds.

Account Holder Signature: Date:

Producer/Agent Name:_____ ID#:_____ Date:_____