



**NDA Sub Group
Group Billing Set Up Form
Fax to: 972-578-0414**



Print or Type

GROUP NAME: NATIONAL DENTAL ASSOCIATION

Enrollment Support: 1-866-971-2368, Ext. 224

Member Company: _____

Requested Effective Date of Coverage _____

Street Address _____ P.O. Box (If Applicable) _____

City _____ State _____ Zip _____ County _____

Main Contact _____ Title _____

Phone Number _____ Fax Number _____ E-Mail _____

ELIGIBILITY

Number of Eligible Employees _____ Number of Enrolled Employees _____

PLANS TO BE OFFERED (Please pick one)

- Select 300 Select 600 Select 800 Select 1000

ENROLLMENT AND BILLING INFORMATION

Enrollment Options: Paper Phone Online

Billing Options: List Bill ACH/ Bank Draft

Signature _____ Date ____/____/____

Name and Title (Print) _____

Home Office Use Only

Region	Effective Date	Trust Policy Number
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Individual Enrollment Form for Group Accident and Sickness Indemnity Insurance

Strata 1 Health Plans™

Underwritten by National Union Fire Insurance Company of Pittsburgh, Pa.

Enrollment Center 1-866-971-2368

Fax Applications to: 972-578-0414

GROUP NAME: _____ REQUESTED EFFECTIVE DATE: _____

Employee Name: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ Gender: _____ Male _____ Female

Date of Birth: _____ E-mail Address: _____

PLAN SELECTION:	STRATA 300	STRATA 600	STRATA 800	STRATA 1000
COVERAGE:	<input type="checkbox"/> \$93 IND	<input type="checkbox"/> \$133 - IND	<input type="checkbox"/> \$171 IND	<input type="checkbox"/> \$197 - IND
	<input type="checkbox"/> \$134 IND+CH	<input type="checkbox"/> \$204 - IND+CH	<input type="checkbox"/> \$266 IND+CH	<input type="checkbox"/> \$321 - IND+CH
	<input type="checkbox"/> \$154 IND+SP	<input type="checkbox"/> \$234 - IND+SP	<input type="checkbox"/> \$308 IND+SP	<input type="checkbox"/> \$360 - IND+SP
	<input type="checkbox"/> \$194 FAMILY	<input type="checkbox"/> \$303 - FAMILY	<input type="checkbox"/> \$402 FAMILY	<input type="checkbox"/> \$483 - FAMILY

SPOUSE & DEPENDENT INFORMATION

(Write spouse's name below if you are applying for Enrollee and Spouse or Enrollee and Family coverage; if no spouse or if spouse is not to be covered, put N/A or "None" in space below.)

Spouse's Name _____ Date of Birth ____/____/____ SS# _____

BENEFICIARY* (Please print full name) _____ Relationship _____

*The enrollee will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.

Dependent Name	Date of Birth	Gender (M/F)
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

By signing below, I and the individuals named herein are eligible for insurance. I understand that this is not basic health insurance or major medical coverage and it is not intended as a substitute for basic health insurance or major medical coverage and that the coverage will not begin until the effective date shown in the coverage document. Premiums deducted on the day of enrollment and on the 19th of every month thereafter. I authorize ADMU Benefits, LLC to collect any and all premiums and fees due for this coverage. By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of coverage as they have been presented to me.

Fraud Warning: Any person who knowingly and with intent, defrauds or deceives any insurance company by submitting an application or filling a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, is guilty of insurance fraud, which is a felony and subject to criminal and/or civil penalties.

Employee Signature

Date