

# SmileChoice<sup>SM</sup>

by Golden West Dental & Vision Plan



## For Individuals, Families and Associations

### Plan 100 and 200 Disclosure Booklet

- Description of Benefits
- Copayments
- Enrollment Form

[www.goldenwestdental.com](http://www.goldenwestdental.com)

This Disclosure Booklet is only a summary of the most important features of the Dental Plan. The Plan Contract and Evidence of Coverage must be consulted to determine the exact terms, limitations, and exclusions of coverage. The enrollee has a right to review a specimen copy of the contract prior to enrollment. A specimen copy of the contract is available at the administrative offices of SmileChoice/Golden West Dental & Vision.

#### Continuity of Care

In the event of termination of this agreement or the agreement with the network dentist, the dentist shall complete all procedures started prior to the termination under the terms of this contract. For example: If a final impression has been taken, dentist will complete the crown, bridge or denture for copayment (plus lab fee where applicable). If assistance is required, member may request such assistance from Plan by calling (800) 995-4124. This continuity of care shall be provided for a term not to exceed 90 days. If you have any questions or need additional assistance, please contact SmileChoice/Golden West Dental & Vision at (800) 995-4124. The Plan Contract and Evidence of Coverage should be read completely and carefully and individuals with special health care needs should read carefully those sections that apply to them.

# Welcome to SmileChoice™!

SmileChoice/Golden West Dental & Vision Plan has been in business since 1974! You are joining a dental plan that brings you exceptional service and savings on dental and vision care for you and your family.

- **Guaranteed acceptance!**

- **No charge for x-rays**

You save \$105 per person every year!

- **No charge for dental exams**

Regular checkups can help prevent future problems.

- **Low-cost routine teeth cleaning**

SmileChoice Plan 200 cleanings are provided at no charge so now it's affordable to have your teeth cleaned twice each year as recommended by dentists!

- **Big savings on dental services**

You'll realize instant savings on everything from fillings to crowns.

- **Cosmetic services covered**

Cosmetic crowns, laminates and even bleaching are all covered!

- **Choice of two dental plans**

SmileChoice Plans are designed to meet your needs and your budget.

- **Choose your personal dentist and vision care provider**

There are hundreds of private, pre-screened dentists and vision care providers to choose from, conveniently located throughout California.

- **Easy to use**

Just show your personal SmileChoice membership card for automatic savings.

- **No deductible**

- **No claim forms to fill out**

- **24-hour emergency service**

A SmileChoice member service representative is available 24 hours each day, because you never know when emergencies will happen.

- **Orthodontic services are covered**

SmileChoice can save you and your family hundreds of dollars.

- **Your savings are unlimited**

There are no annual maximum benefit limitations on the SmileChoice plan!

## Sign up now!

### Look how much you can save!

Plan	**Non-Member	Plan 100	Plan 200
Service	Cost	Cost	Savings
Dental Exam	\$62.50	No Charge	\$62.50
X-rays	\$105.00	No Charge	\$105.00
Routine Cleaning	\$76.00	\$20.00	\$56.00
Filling - 1 Surface	\$115.00	\$33.00	\$82.00
Root Planing	\$185.00	\$75.00	\$110.00
Root Canal, Molar	\$859.50	\$320.00	\$539.50
Porcelain with Metal Crown, Molar	\$737.50	\$380.00	\$357.50
Full Upper Denture	\$1200	\$440.00	\$760.00
Full Upper & Lower Orthodontics (child)	\$4,000	\$1,795	\$2,205
Vision Exam	\$60.00	\$39.00	\$21.00
Single Vision Lenses	\$65.00	25% Savings	25% Savings
Anti-reflective Coat	\$52.00	25% Savings	25% Savings
Frames		25% Savings	25% Savings

\*Subject to a six (6) month waiting period.

\*\*Non-Member cost based on California state average.

## Plan 100 and Plan 200

### Flexible payment options

- **Prepayment Fees**

Plan	Monthly	Annual
<b>Plan 100</b>		
Member only	\$7.64	\$81.35
Member & one (1)	\$12.01	\$129.95
Family	\$14.74	\$159.43
<b>Plan 200</b>		
Member only	\$19.11	\$208.85
Member & one (1)	\$27.85	\$299.75
Family	\$38.22	\$413.60

In addition to your first month's payment, there is a one-time only, non-refundable application fee of \$10.00. The Plan shall not increase the premium to a Member except after a period of 30 days from and after the postage-paid mailing to the Member at the Member's address of record.

## Choose the payment plan that is best for you

SmileChoice's affordable premiums may be paid annually by check, money order, or credit card. Or for greater convenience, choose our automatic monthly checking account withdrawal system or credit card billing. Both offer a convenient way to keep your coverage in force. Instead of one annual premium payment, with your authorization, monthly premiums are deducted from your personal checking account or billed to your credit card. No paper work, no more checks to write. We do the work and you save time and postage costs. It's easy, reliable and automatic!

## Your satisfaction is 100% guaranteed

You'll save money with your SmileChoice membership and you have this Complete Guarantee of Satisfaction:

If you're not satisfied with any SmileChoice Plan at any time, for any reason, you may cancel and receive a full refund of your unused membership fees.

## DESCRIPTION OF DENTAL BENEFITS AND COPAYMENTS

The following is a summary of services of the principal benefits to which members are entitled.

### Services Performed by a Plan General Dentist

	Plan 100	Plan 200
<b>• PREVENTIVE</b>		
Comprehensive oral exam	No Charge	No Charge
Periodic oral exam	No Charge	No Charge
Pulp vitality testing	No Charge	No Charge
Oral hygiene instruction	No Charge	No Charge
X-rays	No Charge	No Charge
Sealants (per tooth)	10.00	10.00
<b>• PROPHYLAXIS (CLEANING)</b>		
Prophylaxis (routine cleaning)	20.00	No Charge
Fluoride treatment	5.00	5.00
<b>• RESTORATIVE</b>		
<b>Amalgam restorations (primary teeth):</b>		
Fillings (1 surface)	30.00	6.00
Fillings (2 surfaces)	38.00	11.00
Fillings (3 surfaces)	47.00	13.00
Fillings (4 or more surfaces)	56.00	19.00
<b>Amalgam restorations (permanent teeth):</b>		
Fillings (1 surface)	33.00	8.00
Fillings (2 surfaces)	44.00	13.00
Fillings (3 surfaces)	51.00	21.00
Fillings (4 or more surfaces)	64.00	24.00
<b>Resin restorations (anterior/front teeth):</b>		
Resin (1 surface)	46.00	18.00
Resin (2 surfaces)	57.00	24.00
Resin (3 surfaces)	72.00	28.00
Resin (4 or more surfaces)	89.00	34.00
<b>Other restorative procedures:</b>		
Sedative filling	28.00	No Charge
Core build-up (including pins)	75.00	No Charge
Pin retention (per tooth)	15.00	No Charge
<b>• CROWNS AND BRIDGES INCLUDING PONTICS (See Note A)</b>		
Porcelain with metal (anterior tooth)	380.00	170.00*
Porcelain with metal (posterior tooth)	380.00	350.00*
Full cast (metal)	340.00	135.00*
3/4 cast (metal)	370.00	135.00*
Stainless steel (primary)	75.00	35.00*
Stainless steel (permanent)	85.00	35.00*
Cast endo post and core (in addition to crown)	120.00	25.00
Prefabricated endo post and core (in addition to crown)	90.00	45.00
Core build-up for retainer (including pins)	75.00	12.00
*Subject to a six (6) month waiting period		
<b>Recementation:</b>		
Inlay, onlay or partial coverage restoration	27.00	10.00
Crown	28.00	10.00
Recement fixed partial denture	43.00	15.00
<b>• ENDODONTICS</b>		
Pulp cap, direct	22.00	No Charge
Therapeutic pulpotomy (excluding final restoration)	50.00	10.00

	Plan 100	Plan 200
<b>Root Canal Therapy (See Note B)</b>		
Anterior	215.00	80.00
Bicuspid	255.00	140.00
Molar	320.00	195.00
Apexification initial visit	98.00	10.00
<b>• PERIODONTICS (See Note B)</b>		
Gingivectomy (per quadrant), (including post-surgical visits)	195.00	80.00
Gingivectomy, treatment (per tooth-fewer than six (6) teeth)	65.00	10.00
Osseous surgery (per quadrant)	340.00	180.00
Subgingival scaling, root planing (per quadrant)	75.00	30.00
Full mouth debridement	50.00	23.00
Perio maintenance procedure (following active therapy)	42.00	28.00
<b>• DENTURES AND PARTIALS</b>		
(Includes Adjustments for Up to Six (6) Months Post-Delivery)		
Complete denture (upper or lower)	440.00	215.00*
Immediate denture (upper or lower)	490.00	250.00*
Partial - acrylic base (upper or lower) (including any clasps and rests)	340.00	150.00*
Partial - cast metal base with acrylic saddles (upper or lower) (including any conventional clasps and rests)	470.00	220.00*
*Subject to a six (6) month waiting period		
<b>• DENTURE AND PARTIAL REPAIRS</b>		
Adjust denture	22.00	No Charge
Rebase denture	165.00	68.00
Chairside relin of full denture	100.00	28.00
Laboratory relin of denture	135.00	63.00
Interim partial denture	180.00	72.00
Special tissue conditioning, per denture	48.00	15.00
Repair denture base	50.00	20.00
Replace missing/broken teeth, denture (per tooth)	48.00	15.00
Repair partial (resin base)	50.00	23.00
Repair partial (framework)	75.00	38.00
Repair or replace clasp	70.00	25.00
Replace tooth (partial)	48.00	20.00
Add tooth to existing partial	63.00	20.00
Add clasp to existing partial	75.00	43.00
<b>• ORAL SURGERY (See Note B)</b>		
<b>Extractions:</b>		
Uncomplicated single tooth (including post-operative visit)	40.00	12.00
Surgical removal of erupted teeth (including post-operative care)	75.00	25.00
Soft tissue impaction	85.00	38.00
Partial bony impaction	120.00	55.00
Complete bony impaction	155.00	70.00
Removal of residual tooth root	80.00	25.00
<b>• ELECTIVE SERVICES</b>		
Resin restorations (posterior teeth):		
Resin (one surface)	60.00	55.00
Resin (two surfaces)	80.00	80.00
Resin (three surfaces)	100.00	95.00
Other elective procedures:		
Cosmetic crown (porcelain with metal)	380.00	350.00
Labial veneers (porcelain laminate)	370.00	335.00
Bleaching (per arch)	170.00	170.00
<b>• PREVENTIVE ORTHODONTICS (See Note B)</b>		
<b>Space maintainers:</b>		
Fixed unilateral	95.00	35.00
Fixed bilateral	135.00	75.00
Removable unilateral	115.00	35.00
Removable bilateral	145.00	85.00
Recent space maintainer	22.00	8.00
<b>Minor treatment to control harmful habits:</b>		
Removable appliance therapy	230.00	35.00
Fixed appliance therapy	270.00	55.00
Office visit for observation, adjustment, or activation (per visit)	22.00	8.00
<b>• GENERAL SERVICES</b>		
Local anesthesia	No Charge	No Charge
Office visit for observation	No Charge	No Charge
Treatment of post-surgical complications	No Charge	No Charge
Occlusal guard - Athletic	130.00	70.00
Occlusal adjustment - limited (per visit)	33.00	10.00
<b>• EMERGENCY VISITS</b>		
Emergency visit palliative (per visit)	33.00	10.00
Emergency visit (after hours)	48.00	28.00
<b>• CONSULTATION</b>		
Consultation, exam at Plan specialist (except Orthodontist)	50.00	50.00
Full mouth x-rays (at specialist only)	48.00	48.00
<b>• MISSED APPOINTMENTS</b>		
Without 24-hour prior notice	20.00	20.00
<b>• RECORD TRANSFER</b>		
Transfer of all materials with less than a full mouth x-ray	10.00	10.00
Transfer of all materials with a full mouth x-ray	21.00	20.00

NOTE A: COST OF HIGH NOBLE METAL (GOLD, ETC.) MAY BE CHARGED EXTRA WHEN USED. NOT TO EXCEED ACTUAL LABORATORY COST OF METAL.

NOTE B: COPAYMENTS LISTED ARE FOR SERVICES PERFORMED BY A PARTICIPATING GENERAL DENTIST. COPAYMENTS FOR SERVICES PERFORMED BY A PARTICIPATING DENTAL SPECIALIST ARE LISTED IN THE SUBSCRIBER CONTRACT.

Deductible	None
Lifetime Maximum	Unlimited covered services rendered by a Network Panel Provider
Outpatient Services*	Not Covered
Hospitalization Services*	Not Covered
Emergency Health Coverage*	Not Covered
Ambulance Services*	Not Covered
Prescription Drug Coverage*	Not Covered
Durable Medical Equipment*	Not Covered
Mental Health Services*	Not Covered
Chemical Dependency Services*	Not Covered
Home Health Services*	Not Covered

\*Golden West is required by regulation to provide this information. Golden West provides Dental, Orthodontic, and Vision benefits only.

## DESCRIPTION OF ORTHODONTIC BENEFITS AND COPAYMENTS

Ortho Plan 4 benefits apply to both plans 100 and 200.

### Initial Examination

No Charge

### Diagnostic Work-up

(Consultation, Study Models and Diagnosis on cases where treatment is prescribed. Payable only if patient does not proceed with treatment)

100.00

### Treatment Fee

Full Upper and Lower Banded Case - Children to age 19

1795.00

Full Upper and Lower Banded Case - Adult\*

1795.00

Limited Upper or Lower Banded Case (Single Arch)

1025.00

Minor Tooth Movement

590.00

Retainer visits and care for six (6) months following completion of treatment period, including cost of retainer appliances

Full Banded Case

200.00

Limited Banded Case (Single Arch)

100.00

Minor Tooth Movement

100.00

Retainer visits after Initial 6-month Period (per visit)

15.00

Broken Appointments (without 24-hour notice)

10.00

\*Some Golden West orthodontic offices limit their practice to children. Please refer to your Golden West Network Directory for information on which offices accept adult cases.

## DESCRIPTION OF VISION BENEFITS AND COPAYMENTS

89E Vision Plan benefits apply to both plans 100 and 200.

### • VISION ANALYSIS

Eye exam including refraction and glaucoma testing

39.00

### • FRAMES AND LENSES

Lenses (All Sizes)

Less 25%\*

Frames (All Sizes)

Less 25%\*

Sunglasses

Less 25%\*

Eyeglass Case

No Charge\*\*

Eyeglass Adjustments

No Charge\*\*

\*Not to be combined with any other offer. \*\*With the purchase of eyeglasses.

### • CONTACT LENSES

#### Daily Wear

Regular Soft

Per Lens

40.00

Extended Wear

Regular Soft

Per Lens

40.00

Tinted

45.00

Tinted

45.00

Toric

70.00

Toric

85.00

Aphakic (Post Cataract)

80.00

Aphakic (Post Cataract)

90.00

#### Disposable & Frequent Replacement

All Types

Less 10%

#### Rigid

Hard Lens (P.M.M.A.)

Per Lens

30.00

Gas Permeable (Daily)

45.00

Gas Permeable (Extended)

60.00

Toric

70.00

Complete fitting and three-month follow-up, carekit and training for contact lenses

Regular Soft, Tinted, Thin or Hard

45.00

Disposable & Frequent Replacement

45.00

All Others Toric, Extended Wear, Bifocal, Gas

Permeable, Monovision, or Aphakic (Post Cataract)

112.00

### • Choice of Dentists, Orthodontists & Vision Care Provider

Each subscriber and eligible dependent must select a participating dentist, orthodontist and vision care provider from the current list of participating dental and vision care offices, or from our website at [www.goldenwestdental.com](http://www.goldenwestdental.com). Select a maximum of three (3) dental, ortho and vision office locations per family (one (1) doctor per member, three (3) per family.)

### • Liability of Subscriber or Enrollee for Payment

In the event the Plan fails to pay the participating provider, the provider will not look to the Member for payment. The Member will not be liable. If the Plan fails to pay a non-participating provider, the Member may be liable to such provider for the cost of services received by that Member.

### • Reimbursement Provisions

Plan Members can be reimbursed up to \$50.00 annually for emergency dental services while more than 30 miles away from the Member's participating Dental Plan Provider, or \$20.00 annually for

emergency vision services while more than 30 miles away from the Member's participating Vision Plan Provider. Proof of receipt of such services must be submitted to the Plan in writing.

• **Facilities**

Participating Providers are available for non-emergency care during their regular office hours. Emergency care is available on a 24-hour basis. Names and locations of the Plan's participating offices are located on the list of participating dental and vision care offices, as well as on our website at [www.goldenwestdental.com](http://www.goldenwestdental.com).

• **Termination of Benefits/Disenrollment**

After the date on which termination becomes effective, the Participating Provider will complete any "service in progress" as defined in the Plan's Subscriber Contract and Evidence of Coverage. Benefits shall cease upon (a) the date coverage expires if not renewed; (b) notice that a satisfactory Provider-patient relationship cannot be established; (c) upon a dependent attaining age 19 (or 23 if full-time student) or upon a dependent's marriage.

• **Grievance Procedure**

Direct all grievances to the Plan. Unresolved grievances will be settled by arbitration.

## DEFINITIONS

**SUBSCRIBER** - Individual in whose name family unit is enrolled.

**MEMBER** - Any individual subscriber or eligible family dependent entitled to receive services under this Agreement.

**DEPENDENT** - Lawful spouse of Subscriber and/or unmarried children to age 19. All unmarried children 19 years or older but less than 23 years old who are full-time students. Coverage will continue beyond the age limitations for dependents who are chiefly dependent upon the Subscriber for support due to retardation or physical handicap. Proof of such continuing dependency must be furnished to Plan upon request.

**BENEFITS** - Services provided under this Agreement. Also referred to as Coverage.

**COPAYMENT** - Additional fees required under this Agreement for specific services. These fees are paid by Member directly to Provider.

**PROVIDER** - A licensed professional who provides services for the Member and with whom the Plan has contracted. Used interchangeably with Facility.

**NON-PANEL PROVIDER** - A licensed professional not under contract with Plan. Service with a non-panel Provider must be authorized in writing by the Plan.

**SERVICE AREA** - Geographic areas within a 30 mile radius from any Plan Provider/Facility.

**CAUSE OR GOOD CAUSE** - Nonpayment of premiums due, fraud or deception by Subscriber, Member or Group or permitting such fraud or deception by another. Breach of any term or condition of this Agreement.

**THERAPEUTIC** - Treatment of disease.

**TREATMENT IN PROGRESS** - Beginning of an irreversible procedure (i.e. tooth prepared for crown/tooth opened for root canal therapy).

## General Exclusions and Limitations on Benefits

1. Treatment must be received from the Member's participating dental or vision care provider unless exception is specifically authorized, in writing, by the Plan.
2. Any procedure not specifically listed as a covered benefit is excluded.
3. Treatment or expenses incurred or in connection with any procedures started prior to the Member's effective date under this Plan or after termination of the Member's coverage are excluded. Example: teeth prepared for crowns, root canal treatment in progress.

## • Dental Exclusions and Limitations on Benefits

1. Prophylaxis procedures are limited to once every six (6) months.
2. Major restorative work (i.e. crowns, bridgework, or dentures) for a period of six (6) months from the effective date of coverage for Plan 200 only.
3. General anesthesia, inhalation sedation, intravenous sedation, or intramuscular sedation.
4. Replacement of lost or stolen dentures, crown and bridge work, or other dental appliances.
5. Treatment of Temporomandibular Joint (TMJ) disturbances, hormonal imbalances, cleft palate, micronathia, macroglossia, and myofunctional therapies are excluded services.

## • Orthodontic Exclusions and Limitations

1. Limited to children under 19 years of age, except where adult cases are accepted as indicated on the provider directory.
2. Treatment copayments are for 24 months of treatment. Treatment in excess of 24 months (extended treatment) is available at usual, customary and reasonable (UCR) fees, payable until treatment is completed (retainers are placed).
3. Subscriber and his or her eligible dependent must remain on the Plan during the period of time the subscriber or his or her eligible dependent is undergoing orthodontic treatment. An early termination will result in usual and customary charges for all unfinished work.
4. Orthodontic treatment must be provided by a member of the SmileChoice orthodontic panel.
5. The following are not benefits included as orthodontia:
  - a. X-rays for orthodontic purposes
  - b. Tracings and photographs
  - c. Phase 1 orthodontic treatment (prior to full mouth banding)
6. Treatment in progress started prior to a Member's eligibility under this Plan.
7. Surgical procedures for orthodontic treatment.
8. Severe or mutilated malocclusions.
9. Retreatment of orthodontic cases.
10. Changes in treatment necessitated by accident of any kind.

## • Vision Exclusions and Limitations

1. Follow-up care for contact lenses shall be limited to a period of three (3) months after the contact lens evaluation. Additional visits are subject to an office visit charge which is set by the doctor's UCR fee.
2. Medical or surgical treatment of the eyes or any procedure requiring an Ophthalmologist or any hospital or medical charges. In the event that Member desires to be hospitalized for any ocular procedure, the cost will be borne by the Member.

## • Other Charges

The Member is responsible for the copayments for services listed in the "Principal Benefits and Coverages Copayment Schedule." Services not listed will be billed to the Member at the dentist's UCR fee.

**SmileChoice™**

by Golden West Dental & Vision Plan  
PO Box 5347  
Oxnard, CA 93031-5347  
(800) 995-4124  
[www.goldenwestdental.com](http://www.goldenwestdental.com)

## **It's easy To join *SmileChoice*™!**

1. Use the attached enrollment form. Select the plan that best suits your needs, either Plan 100 or Plan 200.
2. Fill in your name, address, and phone numbers.
3. List yourself, spouse, and any eligible dependent(s) you wish to enroll. Complete the brief information request about you. Select a participating dentist, orthodontist, and vision care provider from the SmileChoice directory and write the office numbers in the spaces indicated. Select a maximum of three (3) dental, ortho and vision office locations per family (one (1) doctor per member, three (3) per family.)
4. Sign and date where indicated to authorize enrollment.
5. Select the payment plan you want by marking the appropriate box on the enrollment form.
  - To choose annual payment, enclose a check or money order, made payable to SmileChoice, or provide your VISA, Mastercard, AMEX or Discover information.
  - To choose automatic monthly payment by credit card, just indicate the type of card by checking the appropriate box, fill in the card number with expiration date, and sign the "automatic payment authorization". All future payments will automatically be charged to your VISA, Mastercard, AMEX or Discover.
  - To choose monthly payment by automatic checking account deduction, simply check that box on the enrollment form, sign the "automatic payment authorization" and enclose a check made payable to SmileChoice that includes the first months premium and the one-time only, non refundable \$10.00 enrollment fee along with a "voided" check. All future payments will automatically be deducted from your checking account.
6. Make certain all requested information has been provided and that the application is signed. Then mail - it's that easy!

Mail to: SmileChoice  
PO Box 5347  
Oxnard, CA 93031-5347

If we receive your application before the 20th of the month, your coverage will begin the first day of the following month. If we receive your application after the 20th, your coverage will begin on the first day of the second month thereafter.

**Questions? Call our toll-free Member Services line at (800) 995-4124 (Monday - Friday, 8 a.m. to 5 p.m.).**



# SMILECHOICE ENROLLMENT FORM

www.goldenwestdental.com

Plan 100 (SC1)

Plan 200 (SC2)

PLEASE PRINT

Social Security No. - -		Last Name		First Name		Initial	
Street Address			City		State	Zip Code	Home Phone No. ( )
Date of Birth MM/DD/YY / /	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Full-Time Employment MM/DD/YY / /	
Employer				City		Work Phone No. ( )	

### Please complete the following for all family members enrolling in the dental plan.

You may select a Network General Dentist, Orthodontist, and Vision provider for each family member (up to 3 general dentists, orthodontists, and vision providers per family).

Last Name	First Name	MI	Sex	Date of Birth MM/DD/YY	Social Security #	Dentist #	Ortho #	Vision #
<b>SELF</b>								
<b>DO NOT COMPLETE</b>								
Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #1			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #2			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #3			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #4			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #5			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #6			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #7			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			

I wish to enroll in the SmileChoice Plan as an individual. I understand that all necessary dental and vision services will be charged as described in the Description of Benefits and Copayments. By signing this form, or by paying a premium to SmileChoice for coverage for myself and/or eligible dependents, I agree to accept the terms of the SmileChoice Plan Contract and Evidence of Coverage.

Signature \_\_\_\_\_

Date / / \_\_\_\_\_

#### ANNUAL PAYMENT - I wish to pay my annual premium in full

1. Check  Make Check or Money Order payable to SmileChoice
2. Credit Card  VISA  Mastercard  AMEX  Discover

Credit Card Number: \_\_\_\_\_ Exp. \_\_\_\_\_

	<b>Plan 100</b>	<b>Plan 200</b>	
Member only	\$81.35	\$208.85	
Member & one dependent	\$129.95	\$299.75	\$ _____
Family	\$159.43	\$413.60	
One-time only application fee (non refundable)			\$10.00
<b>TOTAL AMOUNT PAID/ENCLOSED</b>			<b>\$ _____</b>

Make check payable and mail completed application to:

**SmileChoice**  
**PO Box 5347**  
**Oxnard, CA 93031-5347**

Agent Code:

Agent Name:

#### AUTOMATIC MONTHLY PAYMENT - I wish to pay my premium automatically monthly

1. Credit Card  VISA  Mastercard  AMEX  Discover   
**Upon receipt of application, first month's premium and application fee will be charged.**

Credit Card Number: \_\_\_\_\_ Exp. \_\_\_\_\_

2. Automatic Checking Account Deduction  **Enclose a Check (No Money Order) payable to SmileChoice for first month's premium and application fee along with a voided check.**

	<b>Plan 100</b>	<b>Plan 200</b>	
Member only	\$7.64	\$19.11	
Member & one dependent	\$12.01	\$27.85	\$ _____
Family	\$14.74	\$38.22	
One-time only application fee (non refundable)			\$10.00
<b>TOTAL AMOUNT PAID/ENCLOSED</b>			<b>\$ _____</b>

I hereby authorize SmileChoice to debit my checking account, or charge my credit card, each month the applicable monthly premium to be credited to my SmileChoice membership. This authorization will remain in effect until I notify Plan in writing, thirty (30) days prior to termination. My bank is authorized to make any necessary corrections. I understand that I will be charged \$10 for any declined or returned debit.

Member's Name (please print) \_\_\_\_\_

Account Holder's Name (please print) \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_ Date / / \_\_\_\_\_