Aegis Administrative Services

Premier Discount Enrollment Form SEIU

☐ Home Care ☐ Personal Assistants ☐ Child Care ☐ Health Systems ☐ Nursing Home ☐ Other

Applicant Name ____

Date of Birth ______/_________/_________Age _______Sex ________

Social Security # _________-___________-____________Telephone _(_______)_________________

Occupation ____

Street Address ____

City ______________________________State _______________Zip _______________

Billing Address (if different) ____

City ______________________________State _______________Zip _______________

Email ____

Complete if spouse and / or children are included:

Spouse's Name ______________________________Date of Birth ____/____/_____

Child's Name ______________________________Date of Birth ____/____/_____

Child's Name ______________________________Date of Birth ____/____/_____

Child's Name ______________________________Date of Birth ____/____/_____

B. CHOOSE YOUR DESIRED MEMBERSHIP

☐ Single $10.00 Per Month

☐ Single plus spouse $16.00 Per Month

☐ Single plus child (max. 2) $16.00 Per Month

☐ Family (3 or more) $18.00 Per Month

☐ Single Annual Rate $120.00

☐ Single plus spouse Annual Rate $192.00

☐ Single plus child (max. 2) Annual Rate $192.00

☐ Family (3 or more) Annual Rate $216.00

C. SELECT YOUR PAYMENT OPTIONS

Total Due :

Select your Payment plan:

☐ Quarterly (credit or debit card, ACH draft) ☐ Annually (credit card, debit card, money order, check)

Select your payment method:

☐ Check or money order. Enclose annual payment to Aegis Administrative Services, Inc.

See page two for ACH authorization

☐ Credit Card: ☐ VISA ☐ Mastercard ☐ Illinois Debit Mastercard (DHS payroll debit card)

Account # ____Expiration _________________________

I authorize Aegis Administrative Services Inc. to charge the above credit card for the premium listed according to the payment mode selected.

Signature ____Date _________________________

THIS IS NOT INSURANCE

C. SELECT YOUR PAYMENT OPTIONS (CONTINUED)

☐Automatic bank withdrawal. Enclose initial payment and a voided check with the application.

Your Aegis Dental Annual fee will automatically be withdrawn from your checking account.

I request that (bank name), ____

(address) ____

For a One Time Payment this authorization is for a single transaction on or after the indicated date. For a Recurring Payment Schedule, I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Aegis Administrative Services, Inc., in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH transaction being rejected for Non Sufficient Funds (NSF) I understand that Aegis Administrative may at its discretion attempt to process the charge again within 30 days and agree to an additional $30.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of the U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

Signature ______________________________ Date ____________________

I hereby apply for membership in Aegis Administrative Services Dental Discount Benefits Plan. I understand that acceptance of this enrollment is guaranteed. I understand that the earliest my membership can become effective is the 1st day of the following month after Aegis's receipt of the completed enrollment form and the first month's payment. As a member of Aegis Administrative Dental Discount Benefit Plan. We understand that your trust in us is one of our most important assets. In order to preserve that trust, we want you to understand our information, practices and your rights to ask us not to share certain information about you. As a member of this plan we want you to know the following: Aegis Administrative Services, will not share any information with any firm or individual not affiliated with Aegis Administrative Services, and will not sell or rent members names with any firm or individual.

Applicant's Signature______________________________**Date**____________________

Signature authorizes release of information and enrollment into the program. The enrollment kits are sent via mail.

THIS IS NOT INSURNANCE

THIS IS A DISCOUNT PLAN

This Discount Program has a 30 day cancellation period. Dental discounts are NOT insurance, and are not intended as a substitute for insurance. Members shall receive a full refund of membership fees, if membership is cancelled within the first 30 days after receipt of membership materials.

For TTY or Relay assistance, please dial 711 then 888-881-2307. For more information on 711 for Telecommunications Relay Service, please visit www.relayillinoisrelay711.com

To file a complaint please call Aegis Customer Service at 733-889-2307. If you are still not satisfied with the outcome you may file a complaint with the Department of Insurance of your state and upon request we will supply you with the phone number.

Aegis Administrative Services, Inc
Premier Dental Discount Program
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Chicago, Il 60707
Toll free: 888-881-2307
Fax: 773-889-2308