DelPacific
INSURANCE SERVICES, LLC
DelPacificis.com
Life • Health • Dental • Disability

PO Box 892919
Temecula, CA 92589-2919
Tel: (951) 926-7565
Tel: (800) 393-3592
Fax: (800) 590-4049
Lic #0F50031
Email: office@dpis1.com

California Dental Network

Easy to apply:

Paying by Check or EFT ?

Fill in and sign where indicated on application and make check payable to:

California Dental Network

Mail your check and application to:
DelPacific Insurance Services
PO Box 892919
Temecula, CA 92589-2919

Paying by Credit Card?

Fill in and sign where indicated on application. *Call us to apply over the phone or Fax or Email your application.*

Call: (951) 926-7565
FAX:(800) 590-4049

Email: dental@dpis1.com

Include your payment to California Dental Network, your monthly premium and the one-time, non-refundable enrollment fee of $10 for Singles, $15 for Couples or $20 per Family.

Completed enrollment applications received by CDN by the 20th of the month will be effective on the first of the following month.

California Dental Network

PLAN SELECTION

Plan #_____

DENTIST SELECTION

Dental Office #_____

AGENT INFORMATION
(if known)

Agent # 1593

Name Del Pacific Insurance

Phone 800-393-3592

ENROLLMENT APPLICATION

Please print or type

Social Security No. | Last Name | First | Initial | Birthday | Home Phone

/ / ( )

Address | City | State | Zip

Employer's Name | Work Telephone ( )

Dependents to be covered:

Spouse: _____ / / Child: _____ / /

Child: _____ / / Child: _____ / /

Last Name (if different) First Birthday Last Name (if different) First Birthday

On behalf of the above named individuals, I hereby apply for enrollment in CDN and certify that the above information is true and correct. NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY DISPUTE WITH THE PLAN, INCLUDING MEDICAL MALPRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL. SEE THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FROM FOR DETAILS.

Applicant's Signature _____ Date _____

Complete this form if you choose to have your monthly premiums deducted automatically from your checking account. Scroll down for credit card option.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED MONTHLY CHECKING ACCOUNT PAYMENTS

Company Name: California Dental Network, Inc. Company ID Number: 3123/0001

I hereby authorize **CALIFORNIA DENTAL NETWORK, INC.**, hereinafter called COMPANY, to initiate debit/credit entries to my account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit/credit the same to such account.

Financial Institution: _____

Transit/ABA No.: _____ Account No.: _____
(First nine numbers from bottom of check)

This authority is to remain in full force and effect until COMPANY and FINANCIAL INSTITUTION have received written notification from me of its termination in such time and in such manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I understand that I may cancel this authorization by providing written notice to the COMPANY at least five business days prior to the payment due date. I further understand that canceling my authorization does not relieve me of the responsibility of paying my account in full.

Date: _____ Name(s): _____

_____
(Please print names here and sign below)

Complete this form if you choose to have your monthly premiums deducted automatically from your credit card.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED MONTHLY CREDIT CARD PAYMENTS

(Until terminated or withdrawn in writing)

Credit Card Type: (Please check one) Am Ex_____ Mastercard_____ Visa_____ Discover_____

Credit Card No.: _____ Name as it appears on Card: _____

Expiration Date: _____ _____

Signature(s): _____ Date: _____