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| **Aegis Administrative Services Enrollment Form SEIU Voluntary Dental Discount Program** |
| * Home Care ☐ Personal Assistants ☐ Child Care ☐ Health Systems ☐ Nursing Home   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 Annual Rate $120.00 * Single plus spouse $16.00 Per Month ☐ Single plus spouse Annual Rate $192.00 * Single plus child (max. 2) $16.00 Per Month ☐ Single plus child (max. 2) Annual Rate $192.00 * Family (3 or more) $18.00 Per Month ☐ Family (3 or more) Annual Rate $216.00 |
| **C. SELECT YOUR PAYMENT OPTIONS** |
| **Total Due :**  **Select your Payment plan:**  □ Monthly (credit card, debit card, money order ACH draft) □ Quarterly (credit or debit card, ACH draft)  ☐ Annually (credit card, debit card, money order, ACH draft)  **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 CVC\_\_\_\_\_\_\_  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** |

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| **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 Your Aegis Dental Annual fee will automatically be withdrawn from your checking account.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 t hat 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 |
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| 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 kit is sent via mail.  **THIS IS NOT INSURNACE 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. Member shall receive a full refund of membership fees, excluding registration fee, 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.illinoisrelay711.com](http://www.illinoisrelay711.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 6970 W. Diversey Ave  Chicago, Il 60707  Toll free: 888-881-2307  Fax: 773-889-2308 |