



## MCNA Dental for Care Access Members

Care Access is pleased to offer MCNA Dental as a attractively priced dental program to Care Access members. To be eligible for MCNA Dental you and/or your family/dependents must be Care Access Members.

Please complete this enrollment application and include all family members.

Select a type of payment desired:

1. *Check* — enclose a check for the premium
2. *Charge* — Send no money, just enter bankcard information and sign the application

Send payments to:  
 Care Access Health Plan  
 PO Box 4276  
 Hallandale, FL 33008



# Signup Request

Name:

Date of Birth:  Phone:

Address:

City:  ST:  Zip:

Care Access ID #:  SSN:

Check coverage for Care Access Members:  Self Only  Self + 1  Family

Please list all Care Access Members to be covered in addition to yourself

Name (Include Last Name if different — All must be Care Access Members)	Date of Birth	Sex	Relationship	Student over 19	Disabled
<input type="text"/>	<input type="text"/>	<input type="text"/>	Spouse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>

I authorize you to charge my:  Visa  MasterCard  Discover  American Express

Cardholders Name:

Cardholders Address:

Cardholders City:  ST:  Zip:

Credit Card Number:

Expiration Date:  Security Code:



**Terms of Acceptance:** I agree to enroll in MCNA Dental Plan. I also understand that the dentist I select may not perform all the services listed on the schedule of benefits. I acknowledge that the dentist I select is an independent contractor who is not an employee of MCNA. I understand that the dentist I select is responsible for the services rendered to me and my dependents. If any, including control of his procedures and personnel. I authorize the dentist who has rendered services to me or members of my family to make available to MCNA my dental records, photo copies or information regarding such services.

**Fraud Statement:** "Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement for claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree."

Applicant Signature X \_\_\_\_\_ Date: \_\_\_\_\_