

ODS Enrollment Application *It is very important that you sign and date below.*

Billing Information: Choose One Option

Option 1: Auto Pay Plan (checking account deduction)

Bank Name: _____ Branch: _____
 Bank Address: _____ Bank Account No.: _____

This authority is to remain in full force and effect until ODS and my bank have received written notifications from me of its termination in such time and in such manner as to afford ODS and my bank a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by notification to my bank in such time as to afford my bank a right to have the amount of an erroneous debit immediately credited to my account by my bank, provided I send written notice of such an error to the bank within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

- Attach a check for one month's premium made payable to Oregon Dental Service, or indicate here if you want the initial premium drafted. Yes No
- Attach a "voided" check from which you want the payment withdrawn.
- Funds will transfer on or around the fifth calendar day of each month.

Signature: _____ Date: _____

Option 2: Monthly Billing Statement

- A \$5 monthly administration fee is required with this payment method.
- Attach a check or money order for one month's premium made payable to Oregon Dental Service. A bill will be sent in the mail every month.

Option 3: Quarterly Billing Statement

- A \$5 quarterly administration fee is required with this payment method.
- Attach a check or money order for three months' premium made payable to Oregon Dental Service.

For Agent Use Only — Reminder: Collect Premium with Application

I, (the Agent) certify I have explained the eligibility provisions to the Applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by ODS, and provided Oregon Disclosure Information required. I CERTIFY THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name (please print or type): Lorraine MASOOD

Agency Name: FG Insurance & Snc Telephone No.: 503 488 5522

Street Address: P.O. Box 476 City: Forest Grove State: OR ZIP: 97116

Agent Signature (required): *Lorraine Masood* Date: _____

Applicant Signature

I understand mailing a check to ODS does not guarantee coverage. The effective date of coverage will be the 1st of the month following the receipt of my application if eligibility is met. If my application does not otherwise meet the eligibility requirements as stipulated, ODS will notify me in writing and my payment will be returned.

Signature: _____ Date: _____
 (or signature of minor's representative for any applicant under age 18)

