BETA Health
"Benefits Done Your Way"

MARS Retiree Dental Plan Enrollment Form - Low Plan Option

I agree to make automatic payments, and I understand that I have the option to pay monthly, quarterly, or annually. Please call Beta Health Association with any questions at (800) 807-0706.

Effective date: _____

Name: _____

Address: _____

E-Mail:_____

Phone number: _____ Date of Birth: _____

Provider (Dentist): _____ Provider #: _____

(See **https://www.alphadentalplan.com/dental-providers/** for a list of network providers.)

Dependents to be covered on the plan:

Spouse's Name: _____ Spouse's Date of Birth: _____

Dependent's Name: _____ Dependent's Date of Birth: _____

Dependent's Name: _____ Dependent's Date of Birth: _____

Step #1 - Select your method of payment (please complete the section that applies to your payment choice)

Credit card recurring payment

Credit Card Number: _____

Type: ☐ MasterCard ☐ Visa ☐ Discover Expiration Date: _____

I authorize automated renewal payments to be taken from the above account for my dental plan:

Signature_____ Date: _____

Checking or savings account recurring payment

Bank Name: _____

Bank Account #: _____ Bank Routing #: _____

I authorize automated renewal payments to be taken from the above account for my dental plan:

Signature_____ Date: _____

Step #2 - Select the frequency of payment

	Monthly	Quarterly	Annually
Member only	☐ $12.75	☐ $38.25	☐ $153.00
Member + 1	☐ $22.75	☐ $68.25	☐ $273.00
Member + Family	☐ $32.75	☐ $98.25	☐ $393.00

Please complete this form and return it to us as soon as possible:

- **BY MAIL**: Beta Health Association, 6200 S Syracuse Way, Suite 460, Greenwood Village, CO 80111
- **BY FAX:** 303-369-1051
- **BY EMAIL:** Operations@betadental.com