



## Good Neighbor Insurance

**AFTER FILLING OUT THIS APPLICATION  
PLEASE MAIL, FAX, OR EMAIL SCAN TO:**

**Good Neighbor Insurance  
690 E. Warner Rd. Suite 117  
Gilbert, AZ 85296, USA**

**Phone: 480-633-9500 / 480-813-9100 • Fax: 480-813-9930**

**[doug@gninsurance.com](mailto:doug@gninsurance.com)**

**[www.gnazhealth.com](http://www.gnazhealth.com)**

### To Get Up-To-Date Insurance Information



**Good Neighbor US Insurance Blog  
[www.gntravelinsurance.com](http://www.gntravelinsurance.com)**



**Tips For Understanding  
US Insurance**



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**TDAHP A800R PRE-PAID/DHMO INDIVIDUAL DENTAL PLAN APPLICATION**

**Thank you for choosing Total Dental Administrators Health Plan, Inc. (TDAHP, Inc.)**

Please complete the entire application.

- Be sure to select your DHMO General Dental Provider from the directory at [www.tdadental.com](http://www.tdadental.com). Write the 5 digit General Dental Provider Number in the space provided on the application. If you have any questions about choosing your General Dental Provider or if you need assistance completing this application, please call your Broker or TDAHP's member services at (602) 266-1995 or toll free at (888) 422-1995.  
**Please Note: Only One Primary General Dental Provider per contract is allowed (contract includes all applicants and dependents).**
- You may change your Primary General Dental Provider selection at any time by notifying TDAHP by phone or in writing prior to the 25th day of the month. The change will be effective the 1st of the following month. If notification is received by TDAHP after the 25th day of the month, the change will be effective the month following next.
- To pay the required A800R annual premium through a convenient **monthly bank account checking withdrawal option**, attach a voided, blank check to this application and complete the "TDAHP Direct Payment Authorization" below. For annual payments, complete the "Credit or Debit Card Direct Payment Authorization" section below. You may also attach a check, money order, or cashier's check for the entire annual payment.
- Partial annual payments will not be accepted and returned to the sender.
- If your application is received by TDAHP prior to the 20th of month, the effective date of your A800R Pre-paid Dental Plan coverage will be the 1st of the following month. If received after the 20th, the effective date shall be the 1st of the month following next.
- Authorization to pay the required A800R annual premium either through monthly payments (EFT only) or annual Credit or Debit Card, Payment must be received by TDAHP prior to the 20th of the month for first of the following month activation.

<u>A800R Pre-Paid /DHMO Plan—Premiums</u>	<u>Monthly Installment</u>	<u>Annual Premium</u>
<input type="checkbox"/> Individual	<b>\$17.00</b>	<b>\$204.00</b>
<input type="checkbox"/> Individual + 1	<b>\$29.00</b>	<b>\$348.00</b>
<input type="checkbox"/> Individual + 2 or more	<b>\$45.00</b>	<b>\$540.00</b>

**ELECTRONIC FUNDS TRANSFER**

*A convenient and affordable method of paying the required annual A800R premiums. Instead of one annual premium payment, we will deduct the required annual premium in monthly installments from your checking or savings account through a no hassle, electronic funds transfer.*

To enroll in the monthly premium payment option, please complete the appropriate section below. Payments are deducted from your account on or about the 20th of each month preceding the month of coverage. (e.g., February 20th payment, for March coverage month)

Please enclose a voided check for your first month's premium, which will initiate the set-up of your monthly electronic funds transfer.

**TDAHP CREDIT OR DEBIT CARD DIRECT PAYMENT AUTHORIZATION FORM**

I authorize TDAHP to initiate entries to debit my account for payment of plan premiums:  Monthly Installments  Annual (Name on card if different: \_\_\_\_\_)

Card type:  VISA  Master Card  Discover Card

Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_ ZIP: \_\_\_\_\_

Premium: \$ \_\_\_\_\_ Full Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**DIRECT PAYMENT AUTHORIZATION FORM (Monthly installment payments only)**

I authorize TDAHP to initiate entries to debit my account for monthly premium installment payments. Please attach a voided, blank check.

**This authority is to remain in force and effect for a minimum of one (1) year. Any request to terminate the Direct Payment Authorization must be received by TDAHP in writing. Any request to terminate your A800R Pre-paid DHMO plan coverage must be submitted to TDAHP in writing.**

Signature: \_\_\_\_\_ Signature (optional for joint account): \_\_\_\_\_

Full name: \_\_\_\_\_ Full name: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Mail your Completed Application and Payment to:**

**Total Dental Administrators Health Plan, Inc. ♦ 2111 East Highland Avenue, Suite 250 ♦ Phoenix, Arizona 85016**