Family Flex PLAN

Lindner DENTAL
ASSOCIATES, P.C.

APPLICATION

Please print clearly. Must be completed in full for processing

APPLICANT INFORMATION		
Name of Account Holder:		
Male Female	Date of Birth:	Social Security:
Current address:		
City:	State:	ZIP Code:
Work phone:	Cell Phone:	Home phone:
Email:		

DENTAL INSURANCE INFORMATION		
Name of Primary Insurance Company:		
Claims address:		City:
State:	ZIP Code:	Phone:
Group #:		ID#:
Subscriber's name:		Male Female
Date of birth:	Social Security:	Employer:
Name of Secondary Insurance:		
Claims address:		City:
State:	ZIP Code:	Phone:
Group #:		ID#:
Subscriber's name:		Male Female
Date of birth:	Social Security:	Employer:

COVERED DEPENDENTS

Name	Date of Birth	Male Female	Relationship to subscriber

CREDIT CARD INFORMATION ***If using an FSA (flexible spending account) card, please provide alternate credit card information****

Account #	MC / VISA / DSCVR/AE	Expiration Date **&** (3 digit v-code from back)

.

All balances remaining after insurance payment **or** charges remaining unpaid 30 days from the original date of service (whichever comes first) will be billed to the credit card indicated above.	lda
Signature of Account Holder:	Date: