



The **Premier** Choice in Dental & Vision Benefits

## AFFORDABLE INDIVIDUAL DENTAL INSURANCE

- ◆ Unlimited Annual Max
- ◆ No Deductibles—295 Covered Procedures
- ◆ No Waiting Periods
- ◆ National Network of 250,000 Access Points

**SEE THE  
DIFFERENCE**

Participants can see a **savings of 53%** vs not having insurance.

PREFERRED PLAN In-Network Provider			AVERAGE NATIONAL COST
D0150	Exam & Cleaning	\$5	\$160
D0274	Bitewing X-Ray	\$0	\$70
D2391	Filling (one surface)	\$38	\$145
D2750	Crown	\$553	\$1,050
D3330	Root Canal	\$543	\$1,000
<b>TOTAL</b>		<b>\$1,139</b>	<b>\$2,425</b>
<b>SAVINGS \$1,139</b> <i>Using an in-network provider</i>			

### PLAN BENEFITS

- ◆ No Pre-Existing Condition Exclusions
- ◆ No Pre-Authorizations
- ◆ Routine Cleaning & Exams: 2 Per Year
- ◆ Discounts on other Specialty Care
- ◆ Lower Out-of-Pocket Costs when using a Network Dentist
- ◆ Lasik Services through Quallsight  
[www.quallsight.com/argusdentalvision](http://www.quallsight.com/argusdentalvision)
- ◆ Discounts on Sun Wear
- ◆ Prescription Drug Discount Card
- ◆ Vision Discount Card

*\*Must be a member of the Nationwide Consumers of America*

*\*Membership fee of \$3 per year for the NCOA is included in the \$35 one time enrollment fee*

#### ARGUS DENTAL & VISION, INC.

Toll Free 844-641-5156 | 4010 W. State Street | Tampa, FL 33609 | [www.argusdentalvision.com](http://www.argusdentalvision.com)

All plans are underwritten by National Guardian Life Insurance Company, rated A- (excellent) by A.M. Best Company.

National Guardian Life Insurance Company is not affiliated with the Guardian Life Insurance Company of America also known as The Guardian or Guardian Life.

Argus Dental & Vision, Inc. a Florida corporation, is a Prepaid Limited Health Service Organization licensed under Florida Statutes, Chapter 636. National Individual Plans Flyer (04/19)

# Enrollment Application

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Street: \_\_\_\_\_ Apt#: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ County: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 How did you hear about Argus Dental & Vision? Web \_\_\_\_\_ Dentist \_\_\_\_\_ Other (please specify) \_\_\_\_\_  
 Dentist Name: \_\_\_\_\_ Agent Name: \_\_\_\_\_

**DEPENDENTS:** Eligible dependents include your spouse and/or any children from birth 26 years of age, or if fully dependent on you for their support.

First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)	TOTAL PREMIUM
Spouse: _____			____/____/____	Premium (Monthly or Annual) \$ _____ + Enrollment/Membership Fee \$ <u>35</u> = <b>Total Payment:</b> \$ _____
Child: _____			____/____/____	
Child: _____			____/____/____	
Child: _____			____/____/____	

## ENROLLMENT

INDIVIDUAL RATES	VALUE	STANDARD	PREFERRED
Individual	\$9.94	\$18.95	\$27.94
Individual & Spouse	\$19.89	\$37.89	\$55.87
Individual & Child(ren)	\$25.32	\$48.22	\$71.12
Individual & Family	\$38.74	\$73.78	\$108.83

\*For monthly billing, your account will be debited or charged by the 15th of each month for one month's premium plus a \$1 monthly service charge.

NOTE: A \$35 one-time enrollment fee applies to your first year of enrollment which includes the \$3 NCOA membership fee.

**METHOD OF PAYMENT: (CHOOSE ONE)**     Credit Card     Check     Bank Draft

American Express    Discover    Master Card    Visa    (Please attach a voided check if paying by monthly bank draft)

Name on Card: \_\_\_\_\_ Name: \_\_\_\_\_

Card #: \_\_\_\_\_ Account #: \_\_\_\_\_

Exp Date: \_\_\_\_/\_\_\_\_/\_\_\_\_    CCV Code: \_\_\_\_\_    Routing Number: \_\_\_\_\_

Amt Charged \$ \_\_\_\_\_    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_    Bank Name: \_\_\_\_\_    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Payment Signature: \_\_\_\_\_

Your signature authorizes Argus Dental & Vision to initiate debit or credit entries to the account indicated. If paying by monthly bank draft, avoided check for the first month's premium must be included with this enrollment application. This authorization is to remain in effect until Argus Dental & Vision has received written notification of your cancellation (must be received by the 10th of the month). Accounts are drafted/charged on the 15th of each month. The monthly billing option includes an additional \$1 recurring fee.

**APPLICATION SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I am applying for dental coverage and by my signature above, I understand this dental plan is a (1) year non-refundable program. I authorize the dentist who has rendered services to me or members of my family to make available to Argus Dental & Vision my dental records, photocopies or information regarding such services to the extent permitted by law. If information is not complete and your signature is not present, the application will not be processed. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.