Farmers' Health Cooperative of Wisconsin

DENTAL ACKNOWLEDGEMENT

Applicant Name:_____

Address: _____

City, State, Zip: _____

County: _____

Phone: _____ Mobile phone: _____

Fax: _____

Email: _____ Website, if applicable: _____

Billing entity:_____

Billing address (if different from above):_____

By the authorized signature below, member applicant:

1. agrees to pay $1.00 for single coverage per month or $1.50 for 2-person coverage per month or $2.00 for family coverage per month added to the monthly insurance premium for monthly cooperative membership dues to cover administrative costs (such dues shall be non-refundable and subject to adjustment from time to time), and

2. agrees to a remain insured for three (3) years unless no longer eligible for Farmers' Health Cooperative, and

3. agrees to pay the full premium for the run out of the three (3) year enrollment period if member applicant terminates coverage prior to the end of the three (3) year period. FHCW will not enforce this provision if the member applicant dies or ceases business operations or for any other reason approved by the FHCW Board of Directors.

Signature: _____ Print name: _____

Title: _____ Date: _____