

- New list bill
- Add-on to existing list bill

Current list bill # _____

Health Plan Administrators, Inc.



Secure DentalOne List Bill Form

Complete the following for a monthly list billing of dental insurance. **Please attach the Individual Applications and payment for the first month's premium and fees due.** The effective date of coverage is on the first of the month. List the month coverage is to begin: _____. Payments are due on the same day as selected each month. Premiums must be paid within the plans stated provision for premium payments, or the dental insurance will terminate.

AUTHORIZED BY: _____ Company Title: _____ Date: _____

Bill to: _____ Billing Contact Person: _____ Phone #: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Applicant's Name * (Last, First)	Select the dental plan (Basic, Classic, Premier)	Indicate whom to be insured 1. Single 2. Single +1 3. Single +2 4. Single +3 5. Single +4 6. Single +5 7. Single +6 or more	Monthly premiums	Monthly Admin. Fee per applicant	One-time enrollment fee per applicant	OrthoCare fee (if applicable)		Total monthly Premium and Fees due
						Individual \$5	Individual +1 or more \$8	
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			
				\$8	\$20			

Make Check Payable to: HPA, Inc.

Send application with payment to:

Mail: Health Plan Administrators, Inc. P.O. Box 340869 Tampa, FL 33694-0869

Toll free Fax: 1-888-FAX-HPA1 (329-4721)

Or call HPA at: 1-800-277-3323 ext. 3

Total Amount Enclosed _____

(First month premium of each applicant must be paid to issue certificate)

Agent Name: _____ Phone #: _____ HPA Code #: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Fax Phone: _____