



Referring Agent: _____

2020 Enrollment Form

send via secure email to support@decent.com,
or fax to (512) 729-7178

Checklist

- Added Referring Agent/Agency Name
- Completed all required fields (requirements are different for virtual plans)
- Provided signature by primary account holder for all agreements

Primary Account Holder

DIRECTIONS:

- All fields required except: Middle Initial; SMS opt-in is required for virtual plans only.
- Primary account holders must be at least 18 years old and no more than 64 years old.

Name:

First Name	MI	Last Name
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Address:

Address Line 1		
Address Line 2		
City	State	Zip Code

Contact:

Phone Number	Email Address
<input type="checkbox"/> Yes, send me SMS notifications about important plan information - standard text messaging rates apply	

Additional Information:

SSN or EIN	Birthdate - MM-DD-YYYY
Tobacco use: <input type="checkbox"/> Within the last 6 months <input type="checkbox"/> Not within the last 6 months	Clinical Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Transgender <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male

Plan selection

DIRECTIONS: Select ONE of the following 2020 plans:

Virtual Pathfinder

Virtual Lonestar

Virtual Trailblazer

Pathfinder

Lonestar

Trailblazer

Account Holder Attestations

Note: This plan is offered to freelancers, sole proprietors, and independent contractors who work at least 20 hours a week, and make enough through their independent work to cover their premiums.



DIRECTIONS:

- Enrollment applications cannot be processed without a signature from the primary account holder agreeing to the Participation Agreement and the Terms and Conditions & Privacy Policy.
- After furnishing a copy of the agreements for review as well as the option to keep a copy of the agreements, please have your client sign below.

By signing below you accept the terms of the Participation Agreement and Terms of Service listed above on behalf of yourself and your eligible dependents.

Primary Account Holder Signature

Signature	Date-DD/MM/YYYY
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Payment

DIRECTIONS: Please complete one of the two payment methods available.

Bank Account:

Account Holder Full Name	Routing Number
Account Number	
Account Type	
<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

Credit Card :

Credit Card Holder Full Name	Credit Card Number
Expiration Date - MM/YYYY	CCV/CVC

Spouse

DIRECTIONS:

- All fields required except: Middle Initial; Phone and SMS opt-in is required for virtual plans only.
- Spouses must be at least 18 years old and no more than 64 years old.

Name:

First Name	MI	Last Name
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Address (If different from Primary Account Holder):

Address Line 1		
Address Line 2		
City	State	Zip Code

Contact:

Phone Number	Email Address
<input type="checkbox"/> Yes, send me SMS notifications about important plan information - standard text messaging rates apply	

Additional Information:

SSN	Birthdate - MM-DD-YYYY
Tobacco use: <input type="checkbox"/> Within the last 6 months <input type="checkbox"/> Not within the last 6 months	Clinical Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Transgender <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male

Children

DIRECTIONS:

- Phone and Email Addresses should NOT be collected for anyone 12 and under.
- Phone, Email Address, and SMS opt-in are required for anyone 18 and older on a virtual plan.
- Phone Numbers and Email addresses must be unique for each individual.
- Children on the plan must be 25 or younger.

Child Name:

First Name	MI	Last Name
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Address (If different from Primary Account Holder):

Address Line 1		
Address Line 2		
City	State	Zip Code

Contact:

Phone Number	Email Address
<input type="checkbox"/> Yes, send me SMS notifications about important plan information - standard text messaging rates apply	

Additional Information:

SSN	Birthdate - MM-DD-YYYY
Tobacco use: <input type="checkbox"/> Within the last 6 months <input type="checkbox"/> Not within the last 6 months	Clinical Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Transgender <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male



Complete this page for each additional child dependent you would like attached to the policy.