Mail To:
LIBERTY Dental Plan of Missouri, Inc.
Mailstop: 60137460
P.O. Box 660535
Dallas, TX 75266-0535

Health Insurance Marketplace

Enrollment Details

Initial Binder #/Subscriber ID:_____ **Proposed Coverage Effective Date:**_____

Total Amount Owed:_____

Subscriber First Name **Subscriber Last Name**

_____ _____

Contact First Name **Contact Last Name**

_____ _____

Contact Phone # **Contact Email**

_____ _____

Payment Information

Name on Card

☐ **Check or Money Order** (Pay to LIBERTY Dental Plan)

☐ **Credit Card** (Complete Portion Below)

Card Type: ☐ MasterCard ☐ Discover ☐ Visa

CC #: **3 Digit Code:** **Expiration Date:**

I authorize LIBERTY Dental Plan to charge the Total Amount Owed to the payment method selected above.

I understand that eligibility will begin on the proposed effective date, pending enrollment confirmation from Federal Exchange MO and successful payment processing.

Signature _____ **Date** _____