MEMBER LAST NAME: FIRST: MI: DOB: SSN#:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS: (CITY, STATE, ZIP)

HOME PHONE: CELL PHONE: EMPLOYEER:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I WISH TO COVER THE ELIGIBLE FAMILY LISTED BELOW: (NAME, DOB)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAYMENT INFORMATION: $10 MONTHLY PREMIUM PER FAMILY MEMBER

PAYMENT METHOD: VISA MASTERCARD AMEX DISCOVER

CARDHOLDER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARD NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVC CODE#:\_\_\_\_\_\_\_\_\_\_\_\_CARD EXPIRATON DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARD HOLDERS SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR CARD WILL BE RAN BY THE 5TH OF EACH MONTH FOR YOUR PREMIUM

NOTICE AND DISCLOSURE

THE VIP DENTAL PLAN IS NOT SUPPPLEMENTAL DENTAL INSURANCE. IT IS A DENTAL PLAN IN WHICH YOUR PARTICIPATING DENTAL PROVIDER HAS AGREED TO PROVIDE PLAN MEMBERS CERTAIN DENTAL SERVICES AT REDUCED FEES. YOU MAY NOT USE THE VIP DENTAL PLAN IN COMBINATION WITH YOUR DENTAL INSRUANCE PLAN FOR PROCEDURES OR SERVICES COVERED BY YOUR DENTAL PLAN. SOME PROCEDURES CANNOT BE PREFORMED IN OUR OFFICE AND WILL BE REFERRED OUT TO A DENTAL SPECIALIST.

YOUR VIP PLAN DISCOUNT WILL NOT BE ACCEPTED OURSIDE OF OUR OFFICE.

YOU MAY USE THE VIP DENTAL PLAN IN CONNECTION WITH YOUR DENTAL INSURANCE PLAN IN THE FOLLOW TWO WAYS.

1. AFTER YOU HAVE EXCEEDED COVERAGE ON YOUR DENTAL INSURANCE PLAN, THE VIP PLAN MAY BE USED; AND
2. IF CERTAIN SERVICES ARE NOT COVERED UNDER YOUR DENTAL INSURANCE PLAN, YOU MAY USE THE VIP PLAN TO ASSIST IN PAYMENT FOR THOSE SERVICES.

YOUR INSURANCE PLAN IS AND REMAINS THE PRIMARY INSURER FOR COVERED SERVICES PROVIDED BY THE PARTICIPATING DENTAL PROVIDER.

BY MY SIGNATURE BELOW, I AFFIRM THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS AND CONDITIONS ASSOCIATED WITH THE VIP DENTAL PLAN OUTLINED ABOVE. IN ADDITION, BY MY SIGNATURE BELOW, I ALSO AGREE TO THE DENTAL PLAN LIMITATIONS AND EXCLUSIONS. I ALSO HAVE TO GIVE A 30 DAY WRITTEN NOTICE SHOULD I DECIDED TO CANCEL THE VIP PLAN. SHOULD I CANCEL, I AM RESPONSIBLE FOR PAYING THE DIFFERENCE BETWEEN THE DISCOUNT RATE I RECEIVED AND THE USUSAL AND CUSTOMARY RATE (UCR) ON PROCEDURES PREFORMED. I KNOW I AM ALSO REQUIRED TO KEEP THE VIP PLAN A MINUMUM OF SIX MONTHS AND KNOW IF I CANCEL BEFORE THAT TIME I WILL BE CHARGED THE PREMIUM OF THE REMAINING TIME IN FULL.

PRINT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATUARE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_