Group Membership Contract
Between
Employer and NewDental.

Employer Name: _________________________________Group Number: ___________
Employer Address: ____
____

Please list bellow all individuals who are applying to become members of NewDental under your group plan.

Employee/Dependent Name	**Discount Plan.** **YEARLY CONTRACT** **No Yearly Max.** **No Waiting period**	**Discount Plan.** **MONTHLY CONTRACT** **No Yearly Max.** **No Waiting period**
Premiums: - Individual: - Individual + Spouse: - Individual + Child: - Individual + Fam. of 3 +	 $100.00/**yr** $120.00/**yr** $120.00/**yr** $160.00/**yr**	 $10.00/mo $12.00/mo $12.00/mo $16.00/mo
Group Admin. Fee:	No Group Adm. Fee	No Group Adm. Fee
Annual Deductible:	No Annual Deductible	No Annual Dedectible
Office Visit Copay:	$10.00 per Visit	$10.00 per visit.
Employee Name: 1.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________	____________________ ____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________ ____________________
Employee Name: 2.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________	____________________ ____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________ ____________________
Employee Name: 3.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________	____________________ ____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________ ____________________

Employee Name: 4.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		
Employee Name: 5.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		
Employee Name: 6.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		
Employee Name: 7.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		
Employee Name: 8.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		
Employee Name: 9.____________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		
Employee Name: 10.___________________ • Dependent Names: 1.____________________ 2.____________________ 3.____________________ 4.____________________		

If additional space is needed, please Copy and use this page.

Terms and Conditions of the NewDental Membership

A. Discount plan. This is a reduced fee plan where members receive significantly reduced price for dental services. However they will owe their reduced portions of the service at the time of treatment. Whether yearly of monthly agreement is elected there are no waiting periods and no yearly maximums on this plan.

1. ***If a yearly contract*** is chosen the yearly membership premium is submitted with this application. If the contract is cancelled before the end of the contractual year there will be no refund returned from NewDental.
2. ***If a monthly contract*** is chosen the monthly membership premiums and the group administration fee will be automatically withdrawn from a credit card or bank account on the first of each month. This membership plan can be canceled at any time by sending a written cancellation request by the 15 of the month to NewDental and cancellation becomes effective on the last day of the month. Unless such a cancellation notice is sent by the 15 of the month this monthly agreement and the contracts between NewDental and Employer are automatically renewed for another month.

- I hereby certify that I have read this document and that the information provided is accurate and complete to the best of my knowledge and that my company and I will abide by the rules and stipulations of this contract.

		Silver	Gold	Platinum
Number of members applying for yearly Preferred 100% Coverage contract	________	______	_____	________
Number of members applying for monthly Preferred 100% Coverage Contract	_______	______	_____	________
Number of members applying for yearly Discount Plan Contract	_______			
Number of members applying for monthly Discount Plan Contract	_______			

Signature of Employer: _________________________________ Date: _________________
(Month, Date, Year)

Print Name of Employer: ________________________________ Title: _________________

Dated at: _______________________________________
(City and State)

Signature of Agent/producer: ____________________________ Date: _______________

Agent/Producer Information	NewDental processor information
Name (print)______________________________ Tax ID/Soc. Sec. number ___________________	Name (print)______________________________ Tax ID/Soc. Sec. number___________________ Date of Membership Approval:______________