

Individual/Family Membership Contract For NewDental

Last name _____ First name _____ Date of birth _____
 Social Security Number _____ Home Phone _____
 Gender: M., F.; Email address: _____ Cell Phone _____
 Street address _____ Apt. _____
 City _____ State _____ Zip Code _____

Please list below all dependents, including your spouse, who are applying for NewDental membership plan.

Individual/Dependent Name	Discount Plan. Mark -Yes -For Yearly Contract	Discount Plan. Mark -Yes -For month Contract
	No Yearly Max. No Waiting period	No Yearly Max. No Waiting period
Premiums:		
- Individual:	<u>\$80.00/yr</u>	<u>\$8.00/mo</u>
- Individual + Spouse:	<u>\$100.00/yr</u>	<u>\$10.00/mo</u>
- Individual + Child:	<u>\$100.00/yr</u>	<u>\$10.00/mo</u>
- Individual + Fam. 4 +:	<u>\$120.00/yr</u>	<u>\$12.00/mo</u>
Annual Deductible:	No Annual Deductible	No Annual Deductible
Office Visit Copay:	\$10.00 per visit	\$10.00 per visit
Individual Name:		
1. _____	_____	_____
• Dependent Names:		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

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 or 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 **If a monthly contract** is chosen the monthly membership premiums will be automatically withdrawn from a credit card or bank account on the first of each month.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 I will abide by the rules and stipulations of this contract.

	Silver	Gold	Platinum
Number applying for YEARLY payment of Preferred 100% Coverage contract	_____	_____	_____
Number applying for MONTHLY payment of Preferred 100% Coverage Contract	_____	_____	_____
Number of members applying for yearly Discount Plan Contract	_____		
Number of members applying for monthly Discount Plan Contract	_____		

Signature of member: _____ Date: _____
(Month, Date, Year)

Print Name of Member: _____

Dated at: _____
(City and State)

Signature of Agent/producer: _____ Date: _____

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