



DIRECT DENTAL PLANS OF AMERICA, INC.

Pioneering Consumer Driven Health Care Plans Since 1994

APPLICATION FOR GROUP ENROLLMENT

Last Name _____ First Name _____ Middle Initial _____

Address _____ City/State/ZIP _____

Birth Date ____/____/____ Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ E-Mail _____

Spouse: _____ DOB: ____/____/____ Child: _____ DOB: ____/____/____

Child: _____ DOB: ____/____/____ Child: _____ DOB: ____/____/____

Child: _____ DOB: ____/____/____ Child: _____ DOB: ____/____/____

Plan Type (Check One): **DDP COLORADO**
 NATIONWIDE NETWORK (AETNA DENTAL/COAST TO COAST VISION/UHS CHIROPRACTIC)
This form does not apply to the United HealthCare Fully Insured Plan offered through DDP. Groups interested in product must begin by requesting a quote and alternative applications will be required.

Plan Selection (Circle initial payment on the applicable plans below):

HIGH OPTION PLAN RATES DENTAL/VISION/CHIROPRACTIC/MASSAGE					DENTAL/VISION RATES					DENTAL/ CHIROPRACTIC/MASSAGE RATES				
	Monthly	Quarterly	Semi-Annual	Annual		Monthly	Quarterly	Semi-Annual	Annual		Monthly	Quarterly	Semi-Annual	Annual
Member	18.65	57.45	112.90	217.80	Member	14.65	45.45	88.90	169.80	Member	13.80	42.90	83.80	159.60
Member+1	29.20	89.10	176.20	344.40	Member+1	22.95	70.35	138.70	269.40	Member+1	22.45	68.85	135.70	263.40
Member+2	34.85	106.50	210.10	412.20	Member+2	29.85	91.05	180.10	352.20	Member+2	26.40	80.70	159.40	310.80
Member+3	39.90	121.20	240.40	472.80	Member+3	34.00	103.50	205.00	402.00	Member+3	31.45	95.85	189.70	371.40
Member+4	44.95	136.35	270.70	533.40	Member+4	38.20	116.10	230.20	452.40	Member+4	36.50	111.00	220.00	432.00
DENTAL ONLY RATES					VISION ONLY RATES					CAREMARK PRESCRIPTION CARD RATES				
Member	9.80	30.90	59.80	111.60	Member	4.85	14.55	29.10	58.20	Member	5.70	17.10	34.20	68.00
Member+1	16.20	50.10	98.20	188.40	Member+1	6.75	20.25	40.50	81.00	Family	9.85	29.55	59.10	118.00
Member+2	21.40	65.70	129.40	250.80	Family	8.45	25.35	50.70	101.40					
Member+3	25.55	78.15	154.30	300.60	CHIROPRACTIC/MASSAGE ONLY RATES									
Member+4	29.75	90.75	179.50	351.00	Family	5.85	17.55	35.10	70.20					

Broker Information:

Broker/Agent Name: _____ DDP Producer #: _____

Payroll Deduction Authorization:

I voluntarily agree to enroll in DIRECT DENTAL PLANS OF AMERICA, INC. I understand that DDP is not insurance and that treatment must be received from a participating provider through the DDP Provider Network. I will not hold DDP accountable for any negligence on the part of the Provider(s). I understand I am responsible for the payment of this plan through a Payroll Deduction for a minimum of one (1) year.

I authorize a Payroll Deduction in the amount of \$ _____ per month. This amount will be deducted from my paycheck beginning in the month of _____, 20____.

Upon termination, I understand that I may continue with the plan as an individual by contacting DDP. If upon termination I choose to discontinue the plan, I must return all membership cards to DDP within 30 days of termination. Failure to return membership cards within 30 days of termination indicated my desires to continue the plan through the annual renewal date. I understand that continuation of the plan requires me to provide back or credit card information in order to automatically draft the previously approved monthly membership fees.

Benefit Waiver: REQUESTING TO WAIVE BENEFITS

Group Employee Signature (Required)

Date