



DIRECT DENTAL PLANS OF AMERICA, INC.

# APPLICATION FOR 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)

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

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

<b>PAYMENT AUTHORIZATION</b>	
Initial Payment Amount	
One-Time Application Fee	
<b>TOTAL INITIAL PAYMENT</b>	

**Broker/Agent Name:** \_\_\_\_\_

**DDP Producer Number:** \_\_\_\_\_

**Method of Payment (Check One and Provide ALL INFORMATION REQUESTED):**

**CREDIT CARD** # \_\_\_\_\_ EXP DATE \_\_\_\_\_

V-CODE \_\_\_\_\_ (3-Digit Security Code found on Signature Pad)

\_\_\_\_\_  
**Authorized Signature for Credit Card (Required)**

**BANK DRAFT** ( ) BUSINESS ACCOUNT ( ) PERSONAL ACCOUNT

NAME ON ACCOUNT \_\_\_\_\_

ROUTING # \_\_\_\_\_ ACCT # \_\_\_\_\_

NAME OF BANK \_\_\_\_\_ BRANCH CITY \_\_\_\_\_

DR. LIC. # OF Authorized Acct Holder \_\_\_\_\_ STATE \_\_\_\_\_

\_\_\_\_\_  
**Authorized Signature for Bank Draft (Required)**

By signature below, applicant agrees to remain enrolled with DDP for a minimum of one-year. After the initial payment, applicant understands that monthly payments will be drafted on the account selected above on the 6th of every month. After the first year, monthly payments will be assessed a \$2.00/month administration fee. Accounts renewing with an annual payment are exempt from administrative fees. Applicant agrees to automatic membership renewal each year unless cancelled by applicant in writing, returning all membership cards, at least 30 days prior to the desired cancellation date and after the one year obligation has been fulfilled. It is further understood that DDP is not a health/dental insurance policy and payments are made directly to the providers for health/dental services. Patient is obligated to pay for all services. Patient will receive discounts for services from providers contracted with the plan indicated above and must utilize network providers to receive benefits. There are no out-of-network benefits. Member will not hold DDP liable for the negligence on the part of a participating provider.

\_\_\_\_\_  
Member Signature (Required)

\_\_\_\_\_  
Date