

Member Enrollment Form

Please complete the following information and mail to:
Dental Direct PO Box 168, Millbrook, NY 12545 • **(888) 310-7808**

dentaldirect
www.dentalplansdirect.com

*Referral Code _____

*Name
last _____ first _____ M.I. _____

*Address
street _____ city _____ state _____ zip _____

*Home Phone _____ Cell Phone _____

*E-mail Address _____

*Date of Birth _____ Gender _____ *Marital Status _____
mm/dd/yyyy

*Required Fields

Additional Member Information

You may register a maximum of 4 financially dependent family members living in your household with each enrollment.
To enroll more than 5 members, please contact us at 888-310-7808 (Each additional member after five family members is \$5 each)

_____ last _____ first Relationship _____ D.O.B. _____

_____ last _____ first Relationship _____ D.O.B. _____

_____ last _____ first Relationship _____ D.O.B. _____

_____ last _____ first Relationship _____ D.O.B. _____

Employment Information

Self Employed Unemployed Employed Employer Paid

*Employer Name _____

*Address
street _____ city _____ state _____ zip _____

*Phone Number _____ Contact Name _____

Paid by Employer
Employer Signature _____ Date _____

*See back to complete information

Billing Information - make money order payable to Dental Direct

- | | |
|--|--|
| <input type="checkbox"/> \$15.00 Monthly - Individual | <input type="checkbox"/> \$150.00 1st. Year \$180.00 Annually - Individual* |
| <input type="checkbox"/> \$25.00 Monthly - Family | <input type="checkbox"/> \$250.00 1st. Year \$300.00 Annually - Family* |
| <input type="checkbox"/> \$9.99 Monthly - Senior 65 & up | <input type="checkbox"/> \$99.90 1st. Year \$119.88 Annually - Senior 65 & up* |

*1st Year price reflects a 20% discount. 2 Months Free is applied to the 1st year of membership.

* Payment must be received by the 15th of the month to be effective on the 1st of the following month

Payment Method - *We Accept Most Major Credit Cards

- | | | | |
|--------------------------------------|-------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Master Card | <input type="checkbox"/> VISA | <input type="checkbox"/> Discover | <input type="checkbox"/> American Express |
|--------------------------------------|-------------------------------|-----------------------------------|---|

Credit Card _____
Account Number _____ Expiration _____ Card Type _____

By signing below, I authorize Dental Direct Discount Membership Program to automatically charge my membership fee or premium on a monthly or annual basis when it is due to the credit card account I have provided. I certify that I am authorized user on this account and that I am at least 18 years of age. I understand that I can terminate my membership or policy at any time according to the terms of my membership agreement or policy.

- Enclosed is a Money Order (Yearly Membership)

*All Money Orders must be for the year in full and the member will be billed annually to renew membership.

SIGNATURE AND ACKNOWLEDGEMENT

By signing, I acknowledge that I have read and understand the Legal Disclaimer Terms and Conditions pertaining to this Discount Membership Program.

Signature

Date

PLEASE MAIL ALL REQUESTS TO

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