



APPLICATION FOR ENROLLMENT

Member Information:

Last Name: _____ First Name _____ Middle Initial _____
 Address: _____ City/State/ZIP: _____
 Birth Date: ____/____/____ Home Phone: _____ Cell Phone: _____ Email: _____
 Employer: _____ Work Phone: _____

Dependents:

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

Plan Type: (Check One): DDP COLORADO – Includes a King Soopers Prescription Discount Plan at No Charge!
 NATIONWIDE NETWORK (AETNA DENTAL/COAST TO COAST VISION/UHS CHIROPRACTIC)

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

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

Method of Payment: (Check One and Provide All Required Information):

CREDIT CARD # _____ EXP DATE _____

Authorized Signature for Credit Card (Required)

BANK DRAFT:

SELECT ONE: () BUSINESS ACCOUNT () PERSONAL ACCOUNT:

Name on Account: _____
 ROUTING # _____ ACCT. # _____
 NAME OF BANK _____ BRANCH CITY _____
 DR. LIC. # of Authorized Account Holder _____ STATE _____

Authorized Signature for Bank Debit (Required)

Payment Authorization:	
Initial Payment:	
Application Fee:	20.00
Total INITIAL Payment:	

- Use the amount selected above for "Initial Payment"
- Add \$20.00 for one-time application fee
- Total to arrive at "Total Initial Payment"

Broker/Agent Name

DDP Producer #

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/mo 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 not a health/dental insurance policy and payments are not 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