



Member Information:

***Required Information**

*Member's Last Name	*First Name	*Middle Initial
*Home Address		
*City	*State	*Zip
*SSN (Last 4 Digits)	*Date of Birth (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
*Phone Number () -	Email Address	

Membership Options:

Member

Dental Plan
<input type="checkbox"/> Single Membership \$96/yr. or \$8/mo.
<input type="checkbox"/> Family Membership \$156/yr. or \$13/mo.
Vision/Hearing Plan - Covers Member & Dependent(s)
<input type="checkbox"/> Add Vision/Hearing Discounts \$24/yr. or \$2/mo.
Prescription/Rx - Covers Member & Dependent(s)
<input type="checkbox"/> Add Prescription/Rx Discounts \$24/yr. or \$2/mo.

Dependent(s) *Please list any additional dependents on a separate sheet.*

First Name	Last Name
Relationship	Date of Birth: (mm/dd/yyyy) / /
First Name	Last Name
Relationship	Date of Birth: (mm/dd/yyyy) / /
First Name	Last Name
Relationship	Date of Birth: (mm/dd/yyyy) / /
First Name	Last Name
Relationship	Date of Birth: (mm/dd/yyyy) / /

Payment Schedule: *(Please Select One)*

<input type="checkbox"/> Annual Payments
<input type="checkbox"/> Monthly Installments*
<small>*A non-refundable \$15 Administration Fee will be added to Membership if Member elects Monthly Installments.</small>

Billing Information:

Bank Draft *(A Voided Check MUST be Attached on Page 2)*

Bank Name	
Routing Number	Account Number

Credit Card

Name on Credit Card	Credit Card Type <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard
Credit Card Number	Card Expiration Date (mm/yy) /
Billing Address (if different from above)	
City	State Zip

MEMBER'S SIGNATURE IS REQUIRED ON PAGE TWO OF THIS ENROLLMENT FORM

PLEASE ATTACH AN ORIGINAL VOIDED CHECK
(FOR BANK DRAFTS ONLY)

Terms and Conditions

This Fee-for-Service Discount Plan Membership Agreement (the "Agreement") is entered into by and between Direct Access Plans, LLC, a Utah limited liability company ("DA"), and the individual whose name and address are herein set forth (the "Member"), on the date indicated next to Member's signature, below, with privileges effective as of the date payment of the membership fee is received by DA (the "Effective Date"). The parties agree that in consideration of payment by Member of the annual membership fee, DA will make available to Member as of the Effective Date the privileges of the Direct Access Fee-for-Service Discount Plan (the "Plan"). Depending on the plan options selected herein and paid or by Member, privileges may include discounts from participating providers ("Providers") of dental, vision, hearing and/or prescription medication services ("Services"). The Plan's Providers and Services are set forth in the New Member Packet, a copy of which is also available on-line at the Direct Access website www.dentistdirectaccess.com. Member understands and agrees that the Providers and Services may change from time to time, as reflected in the updated version of the Provider Panel on the Direct Access website. The term of this Agreement is for one (1) year from the Effective Date, and will be automatically renewed for additional one year terms unless either party sends a written termination that is received by the other party at least 10 days before the end of the current term. Notices shall be sent to the parties' respective addresses as set forth herein or to such other address as a party shall hereafter specify in writing.

The undersigned hereby authorizes Direct Access Plans, LLC to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated herein and the depository indicated herein, hereinafter called "DEPOSITORY," to credit and/or debit the same to such account. This authorization is to remain in full force and effect until Direct Access Plans, LLC has received written notification from me of its termination in such time and in such manner as to afford Direct Access Plans, LLC and DEPOSITORY a reasonable opportunity to act on it.

This program is not insurance. This program offers discounts only at participating Providers and the applicant is responsible to pay the discounted fees negotiated with contract Providers. This Plan is administered by Dentist Direct, LLC located at 75 South 500 West Bountiful, UT 84010, (866) 696-6527.

The Member may rescind this Agreement by sending written notice to DA within 30 days of signing. Member understands and agrees that after the 30-day rescission period, the membership fee becomes non-refundable. If Member has elected to pay in monthly installments, an early termination fee in the amount of Member's annual membership fee (less monthly installments already paid) shall become due in full if the Member chooses to terminate the membership for any reason before the end of the term. A photocopy of this authorization shall be as valid as the original. The administrators have no liability for providing or guaranteeing service or the quality of service rendered.

Signature I have read and agree to the Terms and Conditions detailed above.

Member's Signature	Date Signed / /
Sales Rep Signature	Sales Representative ID #

Fax, Mail, or Scan and Email Completed Enrollment Form to:

Direct Access Plans, LLC
75 South 500 West
Bountiful, UT 84010
Toll-Free: (877) 966-1010
Fax: (801) 299-8365
Email: info@usdentistdirect.com

www.dentistdirectaccess.com