



DIRECT DENTAL PLANS OF AMERICA, INC.

Pioneering Consumer Driven Health Care Plans Since 1994

GROUP MEMBERSHIP AGREEMENT

We agree to offer DDP as the benefit to our employees. Our Accounts Payable Department has been instructed to honor your monthly invoices and to forward the membership fees that are due. We understand that the DDP discount only applies to participating providers. All fees are paid directly to the provider selected by member at time of service. Failure to do so could result in termination of membership. Less than one-year membership may result in being billed from the DDP plan provider at the usual customary rate(s) for the services selected, minus payments for services rendered during membership period. Some fees may vary when unusual services are required. Consult with Provider prior to beginning any treatment. Any procedures done out of network will be paid in full by the employee, not the plan. DDP retains the right to change service, member fees, and provider fee schedule without notice. No cost for services rendered will be paid for by plan.

Change of Service

Employee status changes must be submitted to our office, in writing, no later than the 20th of the month in order to be removed from the next billing cycle. Plan termination will be accepted based on the following criteria: entry into Full-Time Military status; death; change in marital status; employee termination; failure to render payment for services completed by provider. We understand any eligible new membership or termination must be received no later than the 15th of the month prior to the next billing period. Failure to notify in writing any changes in employee status is at no consequence to DDP and employer must pay in full until written notification has been received. Under this agreement, membership shall be for a one-year period from effective date and will automatically renew on a year-to-year basis until 30-day written notice has been received.

We assume no responsibility to DDP after termination of employment for any employee.

I, the undersigned employer, do hereby state that I understand that **DDP IS NOT AN INSURANCE PROGRAM**, and that a full and complete explanation of the discounted fees and services has been given to me, and that I fully accept and subscribe to all the terms and conditions contained in the plan agreement.

Name of Business _____

Authorized Party Name (please print) _____

Authorized Party Title _____

Mailing Address (Street) _____

City _____ State _____ Zip _____

e-Mail _____ Phone _____ Fax _____

Billing Contact Name _____ Phone Number _____

Authorized Party Signature _____ Date _____

Producer Name _____ Producer Number: _____





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APPLICATION FOR LIST BILL ENROLLMENT

	Employee Name	Status *	Plan Type **			Add Care- Mark? Y / N	Initial Payment	Appl Fee	Total Enrollment Amount
			D=DDP Dental	E=Extended Vision	Chiro				
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
Subtotal of Payments							(a)	(b)	(c)

* STATUS: E = Employee Only • ES = Employee/Spouse • EC = Employee/Children • FAM = Family
 ** PLAN TYPE: Choose "D" for DDP Network or "E" for Extended Network (Aetna Dental, Coast to Coast Vision, UHS Chiropractic)

Note: Use Additional forms to add more employees

Authorized Party's Initials: _____

Total # of Employees Enrolled: _____

Total Monthly Payment (a): _____

Total Application Fee (b): _____

Total Initial Payment (c): _____



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LIST BILL PAYMENT AUTHORIZATION FORM

Company Name _____

Initial Payment of \$ _____ paid by: Check Credit Card Auto Bank Draft

Recurring Charges (select one): Monthly Invoice (Plans are billed in advance and are due by the first of the month.) Credit Card Auto Bank Draft

Automatic Credit Card Payments (complete if checked above):

Name on Card _____

Credit Card # _____ Exp Date ____ / ____ CWV _____

Authorized Signature for Credit Card (Required) _____ Date _____

Automatic Bank Draft Payments (complete if checked above):

Name on Account _____

Routing # _____ Acct # _____

Name of Bank _____ Branch City _____ State _____

Authorized Signature for Bank Debit (Required) _____ Date _____

Driver's License # of Authorized Signer _____

By signature above, the company authorizes Direct Dental Plans of America, Inc. to process the initial payment (if credit card or bank draft is selected) and for all monthly payments thereafter from the account indicated above. Monthly payments will be processed on the 6th day of each month. The monthly bank draft amount may vary due to employee termination and/or new enrollments.

Terminations: Company agrees to notify Direct Dental Plans of America, Inc. of any employee terminations in writing. Terminations must be in our office no later than the 20th of the month to be removed from the next billing cycle. Credit or refunds will not be issued for employee terminations that have not been reported in writing (by fax: 303-457-6956 or e-mail: ddp@estreet.com).

Additions: Applications for new enrollees may be faxed or mailed. Effective dates and payments due are as follows:

Between the 1st and 15th of the month:

- For Groups receiving a Monthly Invoice: You must send a check, pay by credit card or bank draft to add a new employee. Membership is effective immediately upon receipt of payment and employee will be added to the next billing cycle.
- For Groups paying by Credit Card or Automatic Bank Draft: Initial payment will be processed immediately upon receipt of application. The next monthly draft amount will be amended to reflect any additions to the group.

Between the 16th and last day of the month:

- For Groups receiving a Monthly Invoice: New employees will be enrolled immediately and the plan amount will be added to the next billing cycle.
- For Groups paying by Credit Card or Automatic Bank Draft: The monthly draft amount will be amended to reflect any additions and will be processed during the next billing cycle.



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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



DIRECT DENTAL PLANS OF AMERICA, INC.

11178 Huron St. Ste 3 Northglenn, CO 80234
303-457-9794 or 800-377-2924 Fax: 303-457-6956

REJECTION OF PLAN CONSENT

I, _____, have been given the opportunity to participate in the Direct Dental Plans of America, Inc., being offered through my employer. It is my decision:

- NOT to cover myself, spouse and children
- NOT to cover my spouse and children

It is further understood that if my employer is contributing towards this benefit that I will not be entitled to receive any moneys in lieu of non-participation.

SIGNED _____ DATE _____