DENTAL ALLIANCE

APPLICATION CARD
(PLEASE PRINT)

DENTAL ALLIANCE USE ONLY **DA IV**	LAST NAME	FIRST NAME		INITIAL	SOCIAL SECURITY NUMBER
EFFECTIVE DATE	STREET ADDRESS	CITY	STATE	ZIP CODE	HOME TELEPHONE
CODE NO.	EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE	BIRTHDATE	DENTAL OFFICE # SELECTED

LIST BELOW ALL YOUR ELIGIBLE DEPENDENTS THAT YOU WISH COVERED:

LAST NAME (IF DIFFERENT)	FIRST NAME	SEX	BIRTHDATE	LAST NAME (IF DIFFERENT)	FIRST NAME	SEX	BIRTHDATE
SPOUSE				CHILD			
CHILD				CHILD			
CHILD				CHILD			

ANNUAL COST (Select the one which will provide your required dental benefits)

☐ Individual $40.00

☐ Individual+1 dependant $75.00

☐ Family (three or more) $110.00

PLEASE DETACH AND MAKE CHECK PAYABLE TO:
Dental Alliance

I WISH TO APPLY FOR THE MEMBERSHIP PROGRAM. I UNDERSTAND THAT ALL NECESSARY DENTAL SERVICES WILL BE CHARGED AS DESCRIBED IN THE DESCRIPTION OF BENEFITS PROGRAM.

APPLICANT'S SIGNATURE _____ DATE _____