

INDIANA DentalPlan

P.O. Box 87459
Baton Rouge, LA 70879
WWW.INDENTALPLAN.COM

Member Information (Please Print)

Date _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Employer _____

Home Phone Number () _____ - _____ Work Phone Number () _____ - _____

Email Address _____

Social Security Number _____ - _____ - _____

Please list dependents to be included

(Spouse and/or Children up to age 21)

Gender

Birth Date

	Gender	Birth Date

	<u>Cost of Plan</u>		
	Single	Two Party	3 or more
Monthly	\$6.00	\$8.00	\$10.00
Quarterly	\$18.00	\$24.00	\$30.00
Semi-Annual	\$36.00	\$48.00	\$60.00
Annual	\$72.00	\$96.00	\$120.00
There is a one time enrollment fee of \$20.00			

Please check method of payment.

_____ Check or Money Order _____ Bank Draft

Note: If you choose to pay by Bank Draft, please send a voided check back along with the application, enrollment fee, and your first month's payment. Your account will be drafted automatically starting on your second month of enrollment.

Please read and sign:

I hereby make application to enroll in the **Indiana Dental Plan**. I hold the **Indiana Dental Plan** blameless for negligence on the part of any participating dentist. By signing this agreement, you hereby agree to be personally liable for all payments due to **Indiana Dental Plan** up to and until the plan is cancelled by you. No Refunds will be issued. If this application is part of a group plan, I hereby authorize my employer to deduct any required contribution from my earnings.

Signature of Applicant _____

Mail application and payment to: United Networks of America – P.O. Box 87459 Baton Rouge Louisiana 70879.

Please remember to:

_____ Complete all information _____ Sign the application _____ Include a voided check (bank draft applicants only)

Office Use Only

Effective Date _____ Policy Number _____

Representative Name _____ Representative Number _____