American Dental Alliance Plans, Inc.

CHANGE FORM

Company/Broker:_____

Please use this form to make changes in an existing dental plan member's status. After completion, fax this form to 913-685-1638.

Current Member Information & Status

Primary Member Name:_____ ID#_____
Street Address, City, State, ZIP:_____
Current Dental Plan:_____ Draft amount: $_____
Coverage Type: Single _____ Couple_____ Family_____

Type of Change

1. Change of Dental Plan: From:_____ To:_____
2. New Street Address, City, State, ZIP: _____
3. Change Dentist: From:_____ To:_____

New Draft Amount: $_____ First Draft Date:_____ (month) ,5th , _____ (year)

4. Change Coverage Type: From: Single _____ To: Single _____
Couple_____ Couple_____
Family_____ Family_____

New Draft Amount: $_____ First Draft Date:_____ (month) ,5th , _____ (year)

5. Deletion of Membership: _____
6. Change Banking Information: _____

In order to change banking informing and/or the amount drafted, the member **must** sign a new bank authorization form below. If a new bank or account is used, please include a voided check or deposit slip with this application.

New Banking Information

Bank Name:_____ Bank Address:_____
City, State, ZIP:_____
Routing Code:_____ Account Number:_____
Checking:_____ Savings:_____ (attach voided check or deposit slip)

I have read and understand the terms and conditions of the Dental Plan and request and authorize Dental Practice Services, Inc. (DPS) to deduct a monthly membership fee of $_____ from my account with the financial institution named above on the 5th of each month or the first business day thereafter. This authority shall remain in effect until revoked by me in writing and until said notice is actually received by DPS. I agree that DPS shall be under no liability whatsoever upon processing these payments in accordance with the terms of the plan.

_____ _____
Member/Account Holder Signature Date