

Premium Plus Plan

Membership Application

Complete the following application for membership and return it with a \$15 non-refundable processing fee to:

American Dental Alliance Plans, Inc. (ADAP), Plan Administrator
PO Box 24273
Overland Park, KS 66283
Phone: 913-851-3039

Your monthly membership fees will begin the 5th of the month following the date your application is approved by ADAP. Acknowledgement of approval together with a copy of the Membership Contract will be mailed to you. You may obtain information as to where and in what manner dental services covered by the Premium Plus Plan maybe obtained by contacting your Primary Dentist at the phone number listed below.

Primary Dentist Information:

LAST NAME	FIRST NAME	MI	PHONE NUMBER:
BUSINESS STREET ADDRESS			FACSIMILE NUMBER:

Principal Member Information:

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER
STREET ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP CODE	AREA CODE & PHONE NUMBER

Dependent Information: (List spouse all eligible dependent children)

LAST NAME	FIRST NAME	MI	RELATIONSHIP	DATE OF BIRTH
1				
2				
3				
4				
5				

Membership Fees:

- SINGLE (\$ 39.00 per month)
- COUPLE (\$ 63.00 per month)
- FAMILY (\$ 89.00 per month)

Authorization for Pre-Arranged Payments:

- Monthly Bank Draft (include voided blank check with application)
- Monthly Bank Draft (include savings deposit slip with application)
- Monthly Credit Card Debit (complete CC form with application)
There is a \$3.00 service charge for every credit card debit

I hereby request membership in the Premium Plus Dental Plan for a period of twelve (12) months beginning on the date that my application is approved. I authorize ADAP to deduct a monthly membership fee and other applicable charges 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 for the minimum twelve month period and thereafter until revoked by me in writing and until said notice is actually received by the financial institution.

Applicant Signature

Date

For Office Use Only

IDENTIFICATION NUMBER	ENCFEE	APDATE	EFDATE	BILLDATE
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