

L O U I S I A N A
dentalplan

P.O. Box 87459
Baton Rouge, LA 70879-7459
WWW.LOUISIANADENTALPLAN.COM

Member Information (Please Print)

Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Home Phone Number () _____ - _____ Work Phone Number () _____ - _____
 Email Address _____

**Please list dependents to be included
(Spouse and/or Children up to age 21)**

	Gender	Date of Birth

MEMBER FEES			
	<u>Individual</u>	<u>Individual (plus one)</u>	<u>Family Plan</u>
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

I hereby make my application to enroll in the **Louisiana Dental Plan**.

Signature of Applicant _____ **Date** _____

Mail application and payment to: Louisiana Dental Plan, P.O. Box 87459, Baton Rouge, LA 70879

Please remember to:

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

By signing this agreement I hereby agree to be personally liable for all payments due to Louisiana Dental Plan until plan is cancelled. I understand that no refunds will be issued. I hold the **Louisiana Dental Plan** blameless for negligence on the part of any participating dentist.

Note: If you choose to pay by Bank Draft, you must send in the enrollment fee, the first month's payment, and a voided check. Your account will be charged or drafted automatically beginning with the second month of enrollment. You may also complete our Bank Draft Application online at WWW.LOUISIANADENTALPLAN.COM. If at any time you wish to cancel your bank draft, you must cancel it at least 5 days prior to the date of the next drafting. There is a \$20.00 fee for all ACH Bank Draft returns and NSF Check returns.

Office Use Only

Effective Date _____ Plan Number _____

Representative Name _____ Representative Number _____