



Member Name _____ Date of Birth _____
(Last, First, Middle) DD/MM/YYYY

Street Address _____

City _____ State _____ ZIP Code _____

Home Phone () _____ Business Phone () _____

| <u>Additional Members</u> | <u>Relationship</u> | <u>Date of Birth</u> |
|---------------------------|---------------------|----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

ANNUAL MEMBERSHIP FEE

or

MONTHLY PAYMENT SCHEDULE

Enrolling one person.....\$89
 Enrolling two people.....\$139
 Enrolling family (spouse and dependent children).....\$169
(Plus nonrefundable \$20 enrollment fee per application)

Enrolling one person.....\$8
 Enrolling two people.....\$12
 Enrolling family (spouse and dependent children).....\$15
(The initial payment should include the first two months' membership fees plus a \$31 enrollment fee. Please include a voided deposit slip or voided check with application.)

Amount paid on date of enrollment \$ _____ Sales Representative _____

Payment type: Cash Check Money Order Credit Card

Visa MC AMEX DISC Card # _____ Exp. Date _____

Signed _____ Date _____

Note: If you cancel within 30 days of the date of purchase, the membership fee(s) paid are refundable. If you cancel after 30 days, the balance remaining will be refunded on a prorated basis. The enrollment fee is not refundable at any time.

Two (2) Access Cards are issued per application. If additional cards are requested, the cost is \$5.00 per card. Cards are the property of U.S. Dental Care. U.S. Dental Care reserves the right to reclaim card(s) at any time.

AGREEMENT FOR PRE-AUTHORIZED PAYMENTS BY U.S. DENTAL CARE, INC.

I (We) hereby authorize U.S. Dental Care, Inc., hereinafter called Company, to initiate debit entries to my (our) checking account indicated below and the depository named below, hereinafter called Depository, to debit the same to such account.

I wish to make payments on the 3rd or 17th of each month. Draft will begin the month of _____

This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. Notice must be received at least 10 business days in advance of the selected draft date. I agree that you shall be fully protected in honoring such check. If the Company receives an N.S.F. from the Depository, the Company will re-debit the Depository's account the following draft period the fee plus a \$20.00 N.S.F. charge. I understand that it is my full responsibility to pay all court costs, all collection fees and/or attorney fees if my account is turned over for collection.

Name _____ Date _____ Amount per month _____

Signed _____