



ENROLLMENT APPLICATION

Dental Discount Medical Plan

Christie Dental

Application Instructions

<p>1. Complete application</p> <p>2. Choose payment option ~ check payable to ADPS or indicate credit card information</p> <p>3. Mail completed & <u>signed</u> form with payment</p>	<p>Mail to: American Dental Professional Services 9054 North Deerbrook Trail Milwaukee, WI 53223</p>
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Check Dental Program & Circle Program Type Desired:

Dental Care Advantage includes dental, vision, chiropractic, prescription drug and hearing programs:

	Member Only	Member +1	Family
Monthly Payer	\$5.50	\$8.50	\$10.50
Annual Payer	\$56.00	\$86.00	\$106.00

Dental Care Advantage Senior Program includes dental, vision, chiropractic and hearing programs for persons age 55 or older.

	Member Only	Member +1
Monthly Payer	\$4.00	\$6.50
Annual Payer	\$42.00	\$74.00

Last Name	First Name	M.I.	Birth date Mo/Day/Yr	Male	Female
<u>Subscriber</u>			/ /		
<u>Spouse</u>			/ /		
<u>Dependents (up to age 19 or 23 if full time student)</u>			/ /		
			/ /		
			/ /		

Street Address

City

State

Zip Code

Phone

Email Address

Family members can be added or removed at any time by contacting the Customer Service Department. Program fees may change if the number of covered members changes. All questions, inquiries or complaints should be directed to our Customer Service Department at 1-888-540-9488, by e-mail at amdps@amdpi.com, by facsimile at 1-877-545-4549, or by mail at: ADPS, 9054 N. Deerbrook Trail, Milwaukee, WI 53223



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Program Payment Options

Check: Make check payable to ADPS for your annual payment. No monthly payments accepted via check.

Credit Card: Fill out credit card information below Monthly payment Annual payment

Visa MasterCard American Express Discover

Credit Card Number _____ Expiration Date _____

Name as it appears on card _____

I authorize American Dental Professional Services to charge my Credit Card account as indicated above.
This authority is to remain in full force and effect until ADPS has received 30-day advance notification from me of the termination of this authority.

Cardholder Signature _____ Today's Date _____

Electronic Fund Transfer - Monthly Payments

Instead of one annual payment, we can deduct monthly payments from your bank account through a quick, no hassle, electronic fund transfer. Please complete the sections below in bold. Payments are due by the 15th of each month for the next month's fee. **Please enclose a check for your FIRST month's fees**, which will initiate the set-up of your electronic fund transfer.

Authorization Agreement

I authorize American Dental Professional Services, LLC (ADPS) to deduct monthly fees for my dental program from my account on or about the 15th of each month. I authorize ADPS to initiate credit entries and debit entries, if necessary, for any credit entries in error to my (our) account and the depository, M & I Marshall & Ilsley Bank, to credit and/or debit the same to such account.

Company Name: American Dental Professional Services, LLC (ADPS)
9054 North Deerbrook Trail; Milwaukee, WI 53223 Telephone # 1-888-540-9488

Customer Name _____

Customer's Address _____

Bank Name _____

Bank Route Code # _____

Bank Account # _____

Monthly Payment \$ _____

Depository Name & Address: M & I Marshall & Ilsley Bank, Milwaukee, WI 53223

This authority is to remain in full force and effect until American Dental Professional Services has received 30-day advance written notification from me (or either of us) of the termination of this authority.

Name: _____
Account Holder Name (Please Print)

Name: _____
Joint Account Holder Name (Please Print)

Signature: _____ / /
Account Holder Signature Date

Signature: _____ / /
Joint Account Holder Signature Date

If at any time you choose to change your mode of payment simply contact our Customer Service Department. Changes in mode of payment can be processed within 30 days of our receipt of the request. Requests to cancel can be made via phone, fax, e-mail or regular mail.

I acknowledge that I have read the program policies, terms and conditions.

Subscriber Signature _____ **Date** _____

ADPS OFFICE USE	Date Received: _____	Date Entered: _____
Effective Date: _____		



TERMS AND CONDITIONS

The Dental Care Advantage and OrthoCare programs provide members access to a network of participating healthcare providers that have agreed to make certain health care services available to members at a pre-negotiated discount. The healthcare services available vary depending on the program you have selected. It may include discounted dental, orthodontic (braces), vision, chiropractic, hearing, or prescription drug services in accordance with a specific pre-negotiated discounted fee schedule. The programs do not discount all procedures. The programs do not provide discounts on other medical or hospital services.

The discounted services are offered by independent providers who are not employees or agents of American Dental Professional Services (ADPS). ADPS does not guarantee the continued participation of any provider in a program and provider fees are subject to change without direct notice. The discount programs may not be used in conjunction with any other plan or program. Please verify your payment responsibility prior to receiving services.

Enrollment Applications received by the 15th of the month will be made effective the 1st of the following month, unless specifically requested by the member to be effective sooner. Annual payers will be effective for 12 months after their initial effective date. An invoice for renewal will be sent to annual payers approximately 45 days before the end of this period. If a renewal payment is not received by the annual termination date, the membership will be cancelled. Monthly payers will be effective as long as the member continues to pay (via credit card or EFT transactions processed by ADPS) the monthly fee for the discount program. Monthly payers must notify ADPS by phone or in writing when they wish to cancel their membership. Membership will be terminated effective the last day of the month that ADPS receives notification.

Membership can be cancelled at any time. Requests to cancel can be made via phone, fax, e-mail or regular mail. If the member cancels the membership within the first thirty (30) days after receipt of the discount card and other membership materials, the member shall receive a reimbursement of all fees paid for the program. If the member cancels the membership after a period of thirty (30) days, the reimbursement of membership fees will be prorated. ADPS reserves the right to terminate a program member from any of the discount programs for any reason including non-payment. In this event program fees will be prorated and refunded in the same manner as noted above.

To find a participating provider for dental, vision, chiropractic or pharmacy services, visit our Web site at www.amdps.com or contact our Customer Service Department at 1-888-540-9488. For Hearing Services, please call EPIC Hearing at 1-866-956-5400 and tell them you are with the Dental Care Advantage Program. When scheduling an appointment with a provider, be sure to reference the correct network and logo listed on your ID card. Present your ID card each time you receive services. Each family member can choose their own contracted health care provider. The program allows conditions existing prior to enrollment to be discounted if the treatment needed is listed in the fee schedule. However, procedures already started prior to the effective date of membership, are not eligible for a discount. You must continue to be a member of the program throughout your entire treatment, including orthodontic care, to be eligible for continued discounted services.

Disclosures

This program is NOT a health insurance policy and the program does not make payments directly to the providers of health services. This program provides discounts at certain locations for health services. The program member is obligated to pay the provider for all the health care services that the member will receive, but the member will receive a pre-negotiated discount from the providers listed in the network, in accordance with the specific pre-negotiated discounted fee schedule. This program does not guarantee the quality of the services or procedures offered by the providers. Discounts vary by provider. The Discount Medical Plan Organization that operates this program is American Dental Professional Services, LLC located at 9054 N. Deerbrook Trail, Milwaukee, WI 53223.