THE CALIFORNIA DENTAL NETWORK

Hello and Welcome to the California Dental Network.

Here is your requested Information. If you have any questions or if there is anything you may need in the meantime, please do not hesitate to e-mail at **info@cadentalnetwork.com** or call the California Dental Network Toll Free at **1-877-433-6825.**

Our Enrollment Website can also Help: www.CaDentalNetwork.com

Network Dentists can be found on the website, or by calling the toll free number.

Don't forget that our dental plans are ...No Deductibles, No Claim Forms, No Annual Maximums, No Limitations on Most Pre-Existing Conditions and No Waiting Periods to See a Dentist!

Our Affordable Rates:

	*Monthly Checking	*Monthly Billing	Annual Billing
Single	$7.95	$8.95	$70.00
Double	$11.95	$12.95	$110.00
Family	$16.95	$17.95	$150.00

Plus one-time non-refundable enrollment fee:
Single $10, Couple $15, Family $20

*Monthly Checking will be automatically deducted from your checking account, Please Attach a Voided Check as well as a check with premium and enrollment

*Monthly Billing: A bill will be sent to you once a month.

To Enroll

Please send the Check (First Premium and Enrollment Fee) and Complete Application to:

California Dental Network
1971 E. 4th Street, Suite 184
Santa Ana, CA 92705-3917

if you would like to have an automatic monthly payment by credit card, fill out credit card form located at the bottom of the application, and send a check with the First Monthly Check Deduction Premium Amount and Enrollment Fee with the application. Following months will be charged to your credit card.

ENROLLMENT APPLICATION **Please print or type. California Dental Network.**

Social Security No. Last Name First Name Initial

Address City State Zip

Home Phone ( ) Email Address Fax ( ) Birthday / /

Employer's Name Work Telephone ( )

Dependents to be covered:

Spouse: / / Child: / /

Child: / / Child: / /

Last Name (if different) First Birthday Last Name (if different) First Birthday

On behalf of the named Individuals, I hereby apply for enrollment in CDN and certify that the above information is true and correct. NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY DISPUTE WITH THE PLAN, INCLUDING MEDICAL MALPRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR CONSTITUTIONAL RIGHT TO A JURY OR TRIAL. SEE THE COMBINED EVIDENCE OF DISCLOSURE FORM FOR DETAILS.

Applicant's Signature Date

PLAN SELECTION **DENTIST SELECTION** **AGENT INFORMATION** (IF KNOWN)

Plan # 460 Dentist Office # _____ Agent 001205 ZINK (760) 944-7068

Complete this form if you choose to have your monthly premiums deducted automatically from your checking account.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Company Name: California Dental Network, Inc. Company ID Number: 3123/0001

I hereby authorize **California Dental Network, INC**., hereinafter called COMPANY, to initiate debit/credit entries to my account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit/credit the same to such account.

Financial Institution:

Transit/ABA No. _____ Account No. _____

This Authority is to remain in full force and effect until COMPANY and FINANCIAL INSTITUTION have received written notification from me of its termination in such time and in such manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I understand that I may cancel this authorization by providing written notice to the COMPANY at least five business days prior to the payment date due date. I further understand that canceling my authorization does not relieve me of the responsibility of paying in full.

Date Signature(s) Name(s) (Please Print)

Complete this form if you choose to have your monthly premiums deducted automatically from your credit card.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED MONTHLY

(Until terminated or withdrawn in writing)

Credit Card Type: (Please Check One) Am Ex _____ MasterCard _____ Visa _____ Discover _____

Credit Card No._____ Name as it appears on Card:_____

(Please print name here and sign below)

Signature(s):_____