



INDIVIDUAL APPLICATION FORM FOR A DISCOUNT MEDICAL PLAN

Please complete this membership application and return via fax to (240) 283-3595, or mail to GDS-MD, Attn: Dental Solutions, 111 Rockville Pike, Suite 950, Rockville, MD 20850.

STEP ONE: CONTACT INFORMATION

LAST NAME		FIRST NAME	
ADDRESS.			CITY, STATE, ZIP
HOME PHONE	WORK PHONE	EMAIL ADDRESS	
SPOUSE'S NAME (IF INCLUDED)			
OTHER HOUSEHOLD MEMBERS (IF INCLUDED)			
1.	5.		
2.	6.		
3.	7.		
4.	8.		

Note: To make changes or additions to your plan, please contact Customer Service at 866.272.7515.

STEP TWO: CIRCLE PLAN TYPE & BILLING*

<u>MEMBER ONLY</u>	<u>MONTHLY</u>	<u>ANNUAL</u>	<u>MEMBER+FAMILY</u>	<u>MONTHLY</u>	<u>ANNUAL</u>
DENTAL	\$8.95	\$89.00	DENTAL	\$11.95	\$119.00
DENTAL, VISION, HEARING & Rx	\$9.95	\$99.00	DENTAL, VISION, HEARING & Rx	\$13.95	\$139.00

*A one-time processing fee of \$4.95 applies to all membership plans

STEP THREE: BILLING INFORMATION—Processing will be delayed on applications received without a form of payment.

I will pay by:

Credit card—Mark one:
 Visa
 Master Card
 Payment Terms (for Credit Card Enrollment Only):
 Monthly
 Annual

Name as it Appears on Card _____ Account# _____

Expiration Date _____

Money order*(Annual Enrollment)
 Personal Check* (Annual Enrollment)

*Please make Check or Money Order payable to GDS-MD

Promo Code: _____

STEP FOUR: BROKER INFORMATION

Broker/Agent Name: _____	Broker/Agent ID#: _____
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Applicant's Signature: _____ Date: _____