DENTAL PROTECTION PLAN, INC

SUBSCRIBER'S APPLICATION

DENTAL PROTECTION PLAN, INC.
7130 W. GREENFIELD AVENUE
WEST ALLIS, WI 53214

(414) 259-9522

NEW ACCOUNT_____RENEWAL ACCOUNT _____ ACCOUNT NUMBER_____

MY DESIGNATED DENTIST IS: _____

COVERAGE: (_____) **INDIVIDUAL** coverage at $40.00 per year.

(_____) **FAMILY** coverage at $50.00 per year.

PERSONAL DATA PLEASE TYPE OR PRINT CLEARLY

Name _____

Address_____

City _____ County_____ State _____ ZIP _____

Telephone No. Home ( ) _____ Work ( )_____

MY QUALIFIED DEPENDENTS FOR FAMILY COVERAGE ARE:

Spouse _____

Children under age 19 (age 25 if full-time students)

_____ DOB _____ _____ DOB_____

_____ DOB _____ _____ DOB_____

Enclosed is my **check made payable to Dental Protection Plan, Inc.** in payment of the annual policy fee.

I hereby apply for a Dental Health Services Contract with DPPI. If accepted by DPPI, I agree to be bound by all of the terms of the Dental Health Services Contract.

Date _____ _____

Applicant's signature

Accepted by DENTAL PROTECTION PLAN, INC. as of the above date or

as of _____ BY _____

APP201608