

Total Dental Administrators, Inc. (TDA), located here in Phoenix; specializes in the development and marketing of dental plans.

G.P.C.C.

TDA-A200S (DHMO)

Premiums

- | | | |
|---|-------------------|---------|
| • Covers Pre-existing Conditions | Employee Only | \$13.71 |
| • 100% Diagnostic Services | Employee + 1 Dep. | \$25.60 |
| • 100% Coverage on Preventative | Employee + Family | \$36.39 |
| • No Maximums | | |
| • No Deductibles | | |
| • No Waiting Periods | | |
| • Comprehensive Specialty Care Benefit | | |
| • No Additional Lab Fees for Semi-precious Metal Change | | |
| • No Additional Lab Fees for Crowns | | |
| • Appointment Availability | | |

Offered through L & A Services, Inc.

Your health & dental broker for over 15 years

Call for further information at (602) 996-6010

Visit our web site at www.LNAservices.com

Prepared by TDA for exclusive use of Greater Phoenix Chamber of Commerce-Arizona 11/04



GROUP DENTAL ENROLLMENT FORM

| | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> New/Rehire Employee | <input type="checkbox"/> Decline Coverage | <input type="checkbox"/> Add Dep. | <input type="checkbox"/> Delete Dep. | <input type="checkbox"/> Cancel Coverage |
| <input type="checkbox"/> Loss of Other Coverage | <input type="checkbox"/> Address Change | <input type="checkbox"/> Provider Change | <input type="checkbox"/> Transfer from PPO | <input type="checkbox"/> COBRA |

| | |
|-------------------------------|-------------------------|
| Name of Employer: G.P.C.C. | Group Number: 539600 |
|-------------------------------|-------------------------|

| |
|--|
| <input checked="" type="checkbox"/> DHMO DENTAL PROGRAM # _____ Dental Office Selected |
|--|

| | | | |
|--|--|--|---|
| Social Security Number: | Effective Date Mo / Day / Year | Date Employed Full Time Month / Day / Year | Hours Worked Per Week |
| Last Name: _____ | First Name: _____ | MI: _____ | Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Home Address: Street: _____ _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ | | Coverage Requested: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Family | |

| Complete for Dependent Coverage: | | | |
|----------------------------------|---------------|------------|-----------------------|
| Spouse Name-Last: | First: | MI: | Date of Birth: |
| _____ | _____ | _____ | ____/____/____ |
| C | 1. | _____ | ____/____/____ |
| H | 2. | _____ | ____/____/____ |
| I | 3. | _____ | ____/____/____ |
| L | 4. | _____ | ____/____/____ |
| D | 5. | _____ | ____/____/____ |
| R | 6. | _____ | ____/____/____ |
| E | | | |
| N | | | |

I hereby authorize payroll deduction, if applicable, and agree that in order to be covered by TDAHP; services must be obtained from or ordered by a TDAHP plan provider, except for emergencies. I hereby apply for enrollment and agree to remain in the plan a minimum of one year, authorize the release of any information relating to dental care received under the plan, and to all terms and conditions set forth in the Group Agreement.

| | |
|---------------------------|-------------|
| Employee Signature: _____ | Date: _____ |
|---------------------------|-------------|

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will need to wait until Open Enrollment.

| | |
|---------------------------|-------------|
| Employee Signature: _____ | Date: _____ |
|---------------------------|-------------|

INSTRUCTIONS
ENROLLING IN THE GROUP DENTAL PLAN
(Automatic Checking or Credit Card)

1. The effective date of your Dental Plan coverage will always be the 1st day of the month. You must submit one month's premium (see#4), complete the Group Dental Plan Application (see #2) and the Authorization for either Direct Monthly Payment or Credit Card Payment. All completed forms and applications must be received by L & A Services, Inc. prior to the 15th day of the month. Coverage will begin on the 1st day of the month thereafter.
2. Complete the Total Dental Administrators Health Plan, Inc. (TDAHP) Group Dental Application (on reverse side). Be sure to list your dependent names and birth dates if you are applying for family coverage.
3. Complete the Direct Monthly Payment Authorization or Credit Card Form. If you are choosing Direct Monthly Payment be sure to include a voided check.
4. Make a check payable to T.D.A.H.P. – for the first month's premium:

Monthly Premium

| | |
|-------------------------------------|---------|
| Employee Only Coverage..... | \$13.71 |
| Employee & One Dependent..... | \$25.60 |
| Employee & Dependents (Family)..... | \$36.39 |

Mail Or Fax All Completed Forms And Applications To:

L & A Services, Inc.
 13444 N. 32nd St., Ste. 12
 Phoenix, AZ 85032-4760
 Fax (602) 996-6790

Call for further information at (602) 996-6010

CREDIT CARD PAYMENT

Name _____ SS# _____
 Amount: _____ Effective _____ Visa Mastercard AM Express
 Card # _____ Expiration Date _____ CVC 2 Number _____
 Name on Card _____ Today's Date _____

DIRECT MONTHLY PAYMENT AUTHORIZATION FORM

I (we) authorize the Company to initiate entries to debit my (our) account described below:

Checking Account # _____ or Savings Account # _____

Financial Institution's Name _____ Address _____

This authority is to remain in full force and effect until the Company has received written notification from me of its termination in such time and manner as to afford the Company a reasonable opportunity to act on it.

 Signature

 Signature (Optional for Joint Account)

 Full Name

 Full Name

 Date Phone Number

 Date Phone Number