

## Progressive Dental Network Membership Enrollment Form

Please complete this form and mail with a check or money order to the address below

First Name:		Last:		MI:
DOB:		Soc. Sec. #:		M      F
Street Address:		City:	ST:	ZIP:
Home Phone:		Present/Previous Employer:		
Do you carry Dental/Health Insurance? No___ Yes___ Ins. Co. Name:				

### Membership information

I would like my membership in the Progressive Dental Network to include:				
<input type="checkbox"/> Myself only				
<input type="checkbox"/> Myself & Spouse		Spouse name:		Spouse DOB:
<input type="checkbox"/> Myself & family		Additional Family members:		
1. Name:		DOB:	2. Name:	
			DOB:	
3. Name:		DOB:	4. Name:	
			DOB:	
Billing method	<input type="checkbox"/> Direct Billing. (A check for annual membership is enclosed)		<input type="checkbox"/> Checkomatic*	
<b>Payment options (choose one):</b> <input type="checkbox"/> *Semi Annual <input type="checkbox"/> Annual * Semi Annual is only available by using *Checkomatic.      Annual may be direct or Checkomatic.				
* If you choose "Checkomatic" billing your payment will be deducted directly from your bank account. You must complete the "Checkomatic" authorization form below to establish this billing method.				
<b>Please enclose a VOIDED check with this application</b>				
By signing this enrollment form and selecting the "Checkomatic" billing method, I am authorizing Golden Age Administrators to deduct the appropriate PDN membership fees from my bank account as listed below. Please debit my account for: <input type="checkbox"/> All future Membership fees <input type="checkbox"/> this transaction only				
Name on Check:		Bank Name:		Routing #
Account #:		Check #:	Debit Amount: \$	

By submitting and signing this form, I state that I have read and fully understand the terms and conditions of this membership. I have read the "disclaimer" and the "Important Network Information" described in the Progressive Dental Network brochure and/or website. I also understand that my membership will be effective immediately upon receipt and acceptance of this form. I understand that my membership will be terminated if I fail to pay the agreed membership fee within 30 days of receipt of an invoice. I am applying for membership in the Progressive Dental Network administered by Golden Age Administrators. I agree to keep my membership for a minimum of one (1) year.

X	X
<b>Applicant's signature</b>	<b>Date</b>
<b>Administered by: Golden Age Administrators, 6800 South Bay Rd. Cicero, NY 13039</b> <b>Phone: 315-698-9800 / 800-270-2226    Fax: 315-698-9807</b> <b>Website address: <a href="http://www.dentalnetwork.net">www.dentalnetwork.net</a>      Email: <a href="mailto:memberservices@dentalnetwork.net">memberservices@dentalnetwork.net</a></b>	