Group Membership Registration

Company Information			
Company Name:			
Alternate Name or DBA:			
Mailing Address:			
City/State/Zip:			
Billing Contact Name:			
Billing Phone:		Fax Number:	
Billing Email:			

Enrollment Information		
Enrollment Effective Date:		
Mail Fulfillment Kit to:	☐ Business Address	☐ Employee's Home Address

Authorized Party	
Authorized Party Name & Title	
Additional Authorized Parties	

Signature: _____ **Date:** _____

TERMS:

By signing this form, you agree on behalf of the Company (the Group) to the following: (1) This agreement lasts for one (1) year from the date benefits begin. The Company has the option to renew annually thereafter. (2) Company is responsible for paying full membership costs to Direct Dental Alliance. If the Company shares the cost with the employee, the Company is responsible for collecting that share on its own terms from the employee. (3) Payments must be made by credit card or ACH by the 10th of every month. (4) The Company is responsible for notifying Direct Dental Alliance if any employees are no longer eligible for benefits before the 20th of the last month of eligibility.

DISCLOSURES

This program is not insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act. Savings will vary by provider, plan, and zip code. The discounts are only available through participating healthcare providers. Services must be paid for by member at the time services are provided. We encourage you to check with your participating provider prior to beginning treatment. This program contains a 30-day cancellation period.