

APPLICATION-Discount Medical Plan Macomb County Discount DenteMax Dental Program



Please complete this application and return:

1. Via Fax: (240) 283-3595 ... or ... 2. By Mail: Macomb County Discount Dental Program, 111 Rockville Pike, Suite 700, Rockville MD, 20850

STEP ONE: PERSONAL INFORMATION

LAST NAME	FIRST NAME	DOB
STREET ADDRESS:		CITY,STATE,ZIP
HOME PHONE:	WORK PHONE:	EMAIL ADDRESS:
OTHER HOUSEHOLD MEMBERS (IF INCLUDED):		
1. _____		
2. _____		
3. _____		
4. _____		

NOTE: To make changes or additions to your membership, please call Customer Service toll free at 1-866-498-7914.

PROGRAM OFFERING*:

DENTAL DISCOUNT PROGRAM \$69 ANNUAL
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*Membership can include up to 9 total persons residing at the same address or students in college.

STEP TWO: BILLING INFORMATION – *Processing will be delayed on applications received without a form of payment.*

I will pay by:

<p>Credit Card – Mark one: <input type="checkbox"/> Visa <input type="checkbox"/> Master Card</p> <p>Name as it appears on Card</p> <p>Name: _____ Card Number: _____</p> <p>Exp. Date: _____</p> <p><input type="checkbox"/> Money Order*</p> <p><input type="checkbox"/> Personal Check*</p>

* Please make check or money order payable to: GDS-MD.

Applicant’s Signature: _____ **Date:** _____