Newport Dental® ConfiDent® **PLAN 3100** (Please print) ***Application for Membership***

Chart #	Last Name	First Name	Initial	SS #	
Effective Date	Street Address	City	State	Zip	Phone Day: Eve:
Agent/Broker	Employer/Organization	Birthdate	M ☐ F ☐	E-mail	Dental Office Code # / Ortho Office Code #

Please List Below All Persons You Wish Covered.

Last Name *(if different)*	Sex	Birthdate

I wish to enroll in the Newport Dental Plan. I understand that all necessary dental services will be charged as described in the description of Benefits and Co-payments, and I and all my eligible dependents are subject to the limitations and exclusions of the Plan.

Status, Fees and Payment Info.

Status	***Fees***
New Member ☐ Renewal ☐	
Member # _____	
Individual ☐ Couple ☐ Family ☐	
Total:	

Payment Information

VISA ☐ ***MASTERCARD*** ☐ ***DISCOVER CARD*** ☐ ***AMER. EXPRESS*** ☐

Please charge by Credit Card. ***Card #***_____

Amt $_____ ***Expiration Date***_____ ***3 digit ID***_____

Signature_____

Please make checks payable to: ***Newport Dental Plan***

ConfiDent®

PLAN 3100

www.newportdental.com

Newport Dental Plan is underwritten by ConsumerHealth, Inc.