



INDIVIDUAL APPLICATION FORM FOR A DISCOUNT MEDICAL PLAN

Please complete this membership application and return via fax to 240-283-3595, or mail to GDS-MD, Attn: Dental Solutions, 111 Rockville Pike, Suite 950, Rockville, MD 20850.

STEP ONE: CONTACT INFORMATION

LAST NAME		FIRST NAME	DOB
ADDRESS			CITY, STATE, ZIP
HOME PHONE	WORK PHONE	EMAIL ADDRESS	
OTHER HOUSEHOLD MEMBER'S NAMES (IF INCLUDED)			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Note: To make changes or additions to your plan, please contact Customer Service at 1-866-272-7515.

STEP TWO: CIRCLE PLAN TYPE & BILLING*

DENTAL, VISION, HEARING & CHIROPRACTIC MONTHLY MEMBERSHIP	
\$7.95 INDIVIDUAL	\$12.45 FAMILY

*A one-time processing fee of \$3.00 applies to all membership plans.

STEP THREE: BILLING INFORMATION—Processing will be delayed on applications received without a form of payment.

I will pay by:

Credit card—Mark one: Visa Master Card

Name as it appears on card _____ Account# _____

Expiration date _____

Applicant's signature: _____ **Date:** _____

DSS DISCOUNT1.2007

Products Administered by Group Dental Service of Maryland, Inc., your Discount Medical Plan Organization, 111 Rockville Pike, Suite 950, Rockville, MD 20850