



Vantage Point

DENTAL PLANS APPLICATION

Vantage Choice
Co-Insurance Plan
TDA PPO Network

Vantage Care
Co-Payment Plan
DHMO Network
Select a dental office from the list of participating providers

DENTAL OFFICE CODE

Vantage Access
Discount Plan Only
TDA PPO Network

THIS PLAN IS A ONE YEAR CONTRACT

Last Name _____ First Name _____ M.I. ____ Gender M F

Address _____ City _____

State _____ Zip Code _____ Birth Date (M/D/Y) _____ Social Security # _____

Phone (____) _____ Email _____ Employer & City _____

DEPENDANT NAME	SEX	BIRTHDATE	DEPENDANT NAME	SEX	BIRTHDATE
Spouse _____	_____	_____	Child _____	_____	_____
Child _____	_____	_____	Child _____	_____	_____
Child _____	_____	_____	Child _____	_____	_____
Child _____	_____	_____	Child _____	_____	_____

IF SUBMITTING A PREMIUM PAYMENT BY CHECK OR MONEY ORDER, MAKE PAYABLE

VOIDED CHECK	<p>PLAN PAYMENT RATES</p> <p>VANTAGE CHOICE</p> <p>Subscriber \$26.61 Subscriber + 1 \$50.25 Subscriber + 2 \$67.00 Subscriber + 3 \$82.70 Subscriber + 4 \$99.31 Subscriber + 5 \$115.08 Subscriber + 6 \$144.34 or more</p>	<p><u>Vantage Care is a one year contract</u></p> <p>VANTAGE CARE</p> <p>Monthly</p> <p>Single \$16.35 Two Party \$32.70 Family \$53.10</p>	<p>DISCOUNT PLAN</p> <p>VANTAGE ACCESS</p> <p>Monthly</p> <p>Single \$6.25 Two Party \$8.25 Family \$10.25</p>	<p>VANTAGE POINT BENEFITS</p> <p>231 East 400 South, Suite 370 Salt Lake City, UT 84111 FAX 801-983-8009 CONTACT US PHONE 801-363-9577 WEB vpdental.com</p>	VOIDED CHECK
	<p>Please select one of the following payment methods Include a \$10.00 one-time enrollment fee with your first payment</p>			<p>APPLICATIONS ARE DUE ON THE 18TH OF THE MONTH PRIOR TO THE APPLICATIONS EFFECTIVE DATE.</p>	

CHECKING OR SAVINGS ACCOUNT Checking Savings

Name of Bank or Credit Union _____

PLAN START DATE
1st day of _____ 20____

Transit / Routing Number

Account Number

CREDIT OR DEBIT CARD

Visa MasterCard Discover

Card # _____ Expiration Date ____ / ____

Account Holder Name (PLEASE PRINT) _____

Monthly Premium \$ _____ + \$10.00 (one-time enrollment fee) = \$ _____

I authorize Total Dental Administrators to debit my account, including the first months premium. I WISH TO ENROLL IN THE PLAN I HAVE SELECTED. **VANTAGE CARE** APPLICANTS AGREE TO REMAIN ON THE PLAN FOR A MINIMUM OF ONE YEAR AND TO RECEIVE CARE FROM A PARTICIPATING PLAN PROVIDER.



Signature (X) _____ Date _____



By becoming a member of the Vantage Point Dental Plans I understand I will be automatically enrolled in the National Consumer's Advantage Association (NCAA) and will be entitled to all of the rights and privileges contained therein.

NCAA National Consumer's Advantage Association
16467 Chesterfield Airport Road, Chesterfield, MO 63017

Vantage Choice Plan Underwritten by American National Life Insurance Company of Texas