

L O U I S I A N A  
**dentalplan**

P.O. Box 87459  
Baton Rouge, LA 70879-7459  
WWW.LOUISIANADENTALPLAN.COM

**Member Information** (Please Print)

Date \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Home Phone Number (    ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone Number (    ) \_\_\_\_\_ - \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please list dependents to be included  
(Spouse and/or Children up to age 21)

	Gender	Date of Birth

<b>ANNUAL MEMBER FEES</b>		
<u>Individual</u>	<u>Individual (plus one)</u>	<u>Family Plan</u>
\$46.00	\$58.00	\$70.00

I hereby make my application to enroll in the **Louisiana Dental Plan**.

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

By signing this agreement I hereby agree to be personally liable for all payments due to Louisiana Dental Plan until plan is cancelled. I understand that no refunds will be issued. I hold the **Louisiana Dental Plan** blameless for negligence on the part of any participating dentist.

**Office Use Only**

Effective Date \_\_\_\_\_ Plan Number LRA \_\_\_\_\_

Representative Name \_\_\_\_\_ Representative Number \_\_\_\_\_

**Mail application and payment to : Louisiana Dental Plan, P.O. Box 87459, Baton Rouge, LA 70879**

***Please remember to:***

\_\_\_\_\_ **Complete all information**    \_\_\_\_\_ **Sign the application**