TDA of Utah
969 E. Murray-Holladay Rd. #4E
Salt Lake City, Utah 84117

DENTAL PLAN GROUP APPLICATION

FOR Standard, Signature & Executive Plans

Phone: (801) 268-9870
Toll Free: (800) 880-3536
Fax: (801) 268-9873

1. Full Legal Name of Applicant: _____

   Address: _____
   Street City State Zip

   Telephone: _____

   Address Correspondence to: _____
   Name Title

2. Affiliated Companies, if any: _____
   Multiple Billings: Yes No If yes, please list additional information on reverse side of form.

3. Nature of Business: _____

4. TDA Plan: **Standard** **Signature** **Executive**
   Add Specialty Care? (please circle one)
   Plus: **YES** **NO**

5. ____ / ____ / ____
   Proposed Effective Date:

6. Total Number of Eligible Employees: _____

7. Total Enrolled: _____

8. _____ Days.
   Waiting Period for New Employees:

9. Employer Contribution:
   EE: _____ % Dep: _____ %

10. Membership Dues:

	# of Employees		
Employee (Only)		=	$
Employee and One Dependent (Two Party)		=	$
Employee and Two of More Dependents (Family)		=	$
Other		=	$
Monthly Administration Fee			
Monthly Premium			
			$

11. Commissions

Payable to:	Agent#:	%
	Agent#:	%
Override:	Agent#:	%

This application is subject to all terms and conditions of the Group Agreement and the approval of the PLAN.

TOTAL CARE

GROUP DENTAL MEMBERSHIP AGREEMENT

Total Care Plan: **Standard:** **Signature:** **Executive:** **Plus (With Specialty Care)**
(Please Circle Appropriate Plans)

This Group Dental Membership Agreement, hereinafter referred to as the "Agreement" is made by and between Total Dental Administrators of Utah, 6985 Union Park Center, Suite 675, Salt Lake City, Utah 84047, hereinafter referred to as the "Plan", and _____hereinafter referred to as the "Group".

This Agreement shall become effective on the ____ day of _____, _____, at 12:01 a.m. and shall remain in effect for an initial term of ____ year(s), subject to the terms and conditions set forth in this Agreement.

In consideration of the payment of Membership Dues (premiums) and the Monthly Group Administrative Fee in the amount and manner herein provided, the Plan agrees to provide dental benefits to eligible Subscribers and said Subscriber's Dependents, if the dependant coverage option has been exercised. Persons receiving coverage, whether as Subscribers or Dependents, may be referred to herein as "Members".

Monthly Membership Dues shall be as follows:

$_____ Subscriber only
$_____ Subscriber and Spouse
$_____ Subscriber and Child(ren)
$_____ Subscriber and Family

Subject to the provisions contained herein, the above Membership Dues (premium rates) are guaranteed for a period of ____ year(s) from the effective date of this Agreement. Dues shall be paid by the Group to the Plan no later than the fifteenth (15th) day of the month prior to the month services are to be provided. The Group shall remit to the Plan the total dues (premium) amount including the following Monthly Group Administrative Fee;

$_____ Monthly Group Administrative Fee

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ARTICLE I
DEFINITIONS

Agreement - This document, the Total Care Plan Schedule of Benefits and co-payments, and any endorsements and riders issued hereunder.

Benefits - The dental services offered, for the co-payments stated, as set forth is this Agreement.

Co-payment - The amount a Member is required to pay at the time he or she receives specified dental care services from a Plan Provider. Co-payment amounts are specified in the Plan Schedule of Benefits and Co-payments.

Dentist - A person who is licensed, by the state which has jurisdiction over said person, to practice dentistry. For the purposes of this Agreement, Dentist shall also mean a physician with respect to the performance of oral surgery, who is properly licensed by the state which has jurisdiction over said physician.

Dental Care - Any care, treatment, services or supplies which are provided or ordered by a Dentist.

Dental Center - A dental practice with one or more Dentists under contract with the Plan to provide covered dental services in accordance with the provisions of this Agreement.

Dependent

1. The Subscriber's lawful spouse except in the case of court ordered separate maintenance.

2. The Subscriber's and/or his/her spouse's unmarried child(ren) by birth or legal adoption, from the date of placement for adoption, who are dependent upon the Subscriber for support, to age twenty-six (26).

3. The Subscriber's and/or his/her spouse's dependant unmarried children who are age twenty-six (26) or older, who have been continuously covered under this Agreement, and who, before age twenty-six (26), have been certified by a physician to be incapable of self-support because of a physical handicap or mental retardation. Subsequent written proof of the continuance of such incapacity and such dependence must be furnished at such intervals as the Plan may reasonably require.

Elective Dentistry - Dental procedures which are unnecessary to the dental health of a Member, as determined by the Plan Provider.

Emergency Care - Dental service required for the relief of severe pain or bleeding, which if not immediately diagnosed and treated, may lead to disability.

Exclusion - Any provision of this Agreement which eliminates coverage for a dental care service.

Experimental - Technology, treatment, procedures, facilities, equipment, drugs, devices of supplies ("technology") which does not meet all of the following criteria:

1. The technology must have final approval from all appropriate governmental regulatory bodies, if applicable.

2. The technology must be available in significant numbers outside the clinical trial or research setting.

3. The available research regarding the technology must be substantial. For purposes of this definition, "substantial" means sufficient to conclude that: 1) The technology is both medically necessary and appropriate for the Member's treatment; 2) The technology is safe and effective; and 3) More likely than not, the technology will be beneficial to the Member's health; and

4. The technology must be generally recognized as appropriate by the regional medical community as a whole.

Group - The organization that makes benefits available to its Members by entering into this Agreement.

Limitations - Any provision, other than an Exclusion, which restricts coverage.

ARTICLE I
DEFINITIONS

Member - Any Subscriber or Dependent of a Subscriber who is enrolled under this Agreement and from whom the Membership Fee required by this Agreement has been paid.

Open Enrollment - A period of at least thirty (30) days prior to the anniversary date of this Agreement, during which all eligible persons in the Group may enroll as Members.

Plan - Total Dental Administrators of Utah, Inc. (TDAUT).

Participating Specialist - A Doctor trained and licensed in orthodontics, endodontics, periodontics, and/or oral surgery who has contracted with TDAUT to provide specialty care to eligible Members in accordance with the provisions of this Agreement.

Plan Provider - a provider of dental care who is licensed by the state which has jurisdiction over said person and has a contract with the Plan to furnish dental care to Members in accordance with the provisions of this Agreement.

Membership Dues - Those amounts required to be paid on a regular prepayment basis by the Group or a Member (or both) each month for the Member to be eligible for benefits the following month.

Schedule of Benefits and Co-payments - The listing of covered dental procedures and applicable Co-payments for a specified Total Care Dental Plan.

Subscriber - a person:

1. Who the Group has determined is eligible;
2. Who has enrolled in the Plan as required by this Agreement; and
3. For whom all Membership Fees have been paid.

ARTICLE II
GENERAL TERMS AND CONDITIONS

Plan Providers

A. Benefits Obtained from Plan Providers - Except for emergency care, Benefits are available only from Plan Providers.

B. List of Providers - A Member may obtain a current list of Plan Providers by making written request to the Plan's Administrator, TDAUT, 969 East Murray Holladay Road, Suite 4E, Salt Lake City, Utah 84117, or by telephoning TDAUT, at (801) 268-9740 or toll free 1-800-880-3536.

C. Choosing a Plan Provider

1. A Subscriber may choose any Plan Provider on the current Plan Provider list. Upon request, the Plan will assist a Subscriber in selecting a Plan Provider; but may not recommend any particular provider.

2. All Members in the same family must go to the same Plan Provider.

3. Each Subscriber is encouraged to choose a Plan Provider at the time of enrollment for coverage and is required to choose a Plan Provider before obtaining benefits.

D. Changing plan Providers - A Subscriber may change Plan Providers if the Subscriber notifies the Plan, in writing, by the twentieth (20th) day of the month prior to the month that the change is to take place. Provided that notice is given as herein set forth, the change will be effective on the first day of the following month. Should the Subscriber's Plan Provider stop participating in the Plan, the Plan reserves the right to transfer the Subscriber to another Plan Provider of the Subscriber's choosing.

Eligibility

A. Initial enrollment must be made within thirty (30) days following the date of hire or the Group's period of probation. An application card must be filled out and returned to the Group, who will then send it to TDAUT so that coverage can begin in accordance with the effective date of coverage as contained herein.

ARTICLE II
GENERAL TERMS AND CONDITIONS

Eligibility (Cont.)

B. A spouse and child(ren) newly acquired through marriage must make application within thirty (30) days of marriage.

C. Natural child(ren) of the Subscriber and spouse born while the Subscriber is covered under this Agreement are covered from the date of birth. However, the Subscriber must make application for coverage of a newborn child within sixty (60) days from the child's date of birth for coverage to continue for that child.

D. Newly acquired adopted children are covered from the date they are placed with the Subscriber for adoption. However, the Subscriber must make application within sixty (60) days from the date of placement for coverage to continue for that child.

E. Eligible Dependents include the lawful spouse of the Subscriber and the unmarried dependant children of the Subscriber and/or Subscriber's spouse, including children placed for adoption with Subscriber, to age twenty-six (26). Eligible family Dependents who do no enroll during the initial enrollment period, and or in accordance with paragraphs B,C, or D Above, cannot enroll until the next open enrollment period, except as set forth below. Dependents in military service are not eligible.

F. A Dependent child may continue coverage under this Agreement upon reaching twenty-six (26) years of age, if the child continues to meet the Number 3 definition of Dependent, see Definitions, page 1, and the Subscriber remains covered under this Agreement and the appropriate Membership Dues (premiums) are paid.

Effective Date of Coverage

All Subscribers, who are eligible for coverage under this Agreement, who have paid the appropriate Membership Dues (premiums) prior to the fifteenth (15th) day of the prior month, shall be eligible for Benefits commencing on the first day of the following month. Membership Dues (premiums) received between the fifteenth (15th) day of the month and the last day of the month shall be eligible for Benefits commencing the first day of the second month thereafter.

Payment of Membership Dues (Premiums)

All Membership Dues (premiums) are payable on or before the 15th day of the month preceding the month in which services may be rendered. Under this Agreement, the Group shall pay the Membership Dues (premiums) on behalf of the Subscriber and/or the Subscriber's Dependents. Any arrangements between the Group and the Subscriber under which the Subscriber is to reimburse the Group for any portion of the Membership Dues (premium) are entirely between the Group and the Subscriber. The Plan looks solely to the Group for payment of Membership Dues (premiums). The Group is solely responsible for notification to Subscribers of Termination of this Agreement for non-payment of Membership Dues (premiums).

Continuation of Dental Coverage

A. Subscriber or Subscriber and Dependents may continue dental coverage should eligibility under this Agreement cease. Subscriber must send a written request for continuation of coverage with appropriate Membership Dues to TDAUT within thirty (30) days of the date eligibility ceases under this Agreement. Note: The continuation coverage herein offered, may provide different benefits and/or a different level of Benefits than those offered by the Plan.

B. Under Federal and State laws, Subscribers and/or Subscriber's Dependents may be eligible to continue coverage under the Plan for a limited period after such coverage would otherwise terminate. Events after which this type of continuation may be available are:

1. The Subscriber's termination of employment or reduction in working hours;
2. The Subscriber's death;
3. The Subscriber's divorce or legal separation;
4. The Subscriber's entitlement to Medicare benefits; and
5. The Subscriber's child's loss of eligibility as a dependent of Subscriber.

The Group shall provide notification and details for continuation of Group coverage to Subscribers and their Dependents as required under the COBRA Act.

ARTICLE II
GENERAL TERMS AND CONDITIONS

Termination

A. Dental coverage provided under this Agreement will cease at the end of the period for which Membership Dues (premiums) were paid when the following occurs:

1. The Subscriber and all Dependents when:

   a. The Subscriber's employment or connection with the Group ceases; or
   b. This Agreement is terminated; or
   c. The Group fails to submit the Membership Dues (premiums) for any covered Member.

2. The Dependent children when they:

   a. Reach age twenty-six (26), unless said child meets the Number 3 definitions of Dependent , see Definitions, page 1; or
   b. Marry; or
   c. Are no longer dependent upon the Subscriber for Support.

3. The spouse when his or her marriage is dissolved, annulled, or otherwise terminated.

B. Notice to the Plan of termination by the Group and/or Subscriber. The Plan must be notified in writing within thirty (30) days of a covered Member's termination. Requests for retroactive adjustment of Membership Dues beyond the thirty (30) day limit will not be considered.

C. Notice to the Subscriber of termination by the Group and/or the Plan. In the event of termination of this Agreement by either TDAUT and/or the Group, the Group shall give thirty (30) days prior written notice of termination to each Group Member and shall notify each Group Member of his/her rights to continue coverage upon termination.

Grievance Procedure

A complaint is any oral or written expression of concern or dissatisfaction regarding a Total Care service or procedure, whether dental or non-dental in nature. If the Group or Member has a complaint, an initial attempt should be made to resolve it by communicating with Total Care's Customer Service Department. in most cases, a satisfactory resolution can be reached in this manner. However, if a resolution cannot be reached in this manner, a more formal grievance process can be used. This formal process will operate as follows:

A. The Group or Member may file a written complaint/grievance with the Administrator of the Plan, TDAUT at:

Total Dental Administrators of Utah (TDAUT)
6985 Union Park Center, Suite 675
Salt Lake City, Utah 84047

This written request for action on the grievance must be received by TDAUT within thirty (30) days of the occurrence which generates the complaint or grievance.

B. Required information in the written request for action shall include the name of the Group and Subscriber's name, address, telephone number, the nature of the complaint/grievance, the facts upon which the issue is based and the resolution sought. Necessary facts include dates of services, place of service, providers involved, and types of service/procedure received if applicable. In addition, TDAUT may request any further information it deems necessary.

C. Final written or verbal resolution by TDAUT shall be made no later than thirty (30) calendar days following initial receipt of the written complaint/grievance in TDAUT's office.

ARTICLE III
COORDINATION OF BENEFITS WORKERS' COMPENSATION EXCLUSION AND THIRD PARTY LIABILITY

Coordination of Benefits

A. This Coordination of Benefits (COB) provision applies to this Plan when a covered Member also has other dental care coverage(s) under:

1. Group Insurance or group-type coverage, whether insured or uninsured, including prepayment, group practice or individual practice coverage. This also includes coverage for students other than school accident-type coverage; or

2. Coverage under a governmental plan required or provided by law, except a state plan under Medicaid or under any plan when, by law, its benefits are excess to those of any private dental care program or other non-governmental program; or

3. Coverage under an individual policy contracted by the Member with an insurance carrier,

B. In the event benefits are available pursuant to this plan and other dental care coverages, the order of benefit determination rules will apply:

1. The Benefits under this Plan shall not be reduced when, under the order of benefit determination rules, this Plan determines benefits before another dental care coverage, but may be reduced when, under those rules, another dental care coverage determines its benefits first.

2. If the other dental care coverage does not contain a coordination of benefits provision, the benefits of that coverage will be determined before any Benefits under this Plan are determined.

3. If the other dental care coverage contains a coordination of benefits provision, the rules establishing the order of benefit determination are as follows:

a. The benefits of the dental care coverage which covers the person (to whom the service relates) as other than a Dependent shall be determined before the benefits of a dental care coverage which covers such a person as a Dependent.

b. When child(ren) are patients and where the parents are not separated or divorced, the benefits of the dental care coverage of the parent whose birthday, that is, month and day of the month, falls earlier in a year, are determined before those of the health care coverage of the parent whose birthday falls later in the year.

Note: If both parents have the same birthday (month and day of the month), the benefits of the dental care coverage which covered the parent longer are determined first.

Note: If the other dental care coverage does not have the rule in 3(b) above; but instead has a rule based upon the gender of the parent, and if, as a result, it and this Agreement do not agree on the order of benefits, the rule in the other dental care coverage will determine the order of benefits.

c. When child(ren) are patients and where the parent are separated or divorced, the following rules apply:

(1) Benefits are determined first by the dental coverage of the parent with the custody of the child(ren);
(2) Then by the dental care coverage of the spouse (if any) of the parent with custody of the child(ren); and
(3) Finally, by the dental care coverage of the parent not having custody of the child(ren).

ARTICLE III
COORDINATION OF BENEFITS, WORKERS' COMPENSATION EXCLUSION AND THIRD PARTY LIABILITY

Note: If the specific terms of the court decree state that one of the parents is responsible for the dental care expenses of the child(ren), and the entity obligated to pay or provide the benefits of the dental care coverage of that parent has actual knowledge of those terms, the benefits of that dental care coverage are determined first. This does not apply with respect to any claim determination period or year during which benefits are actually paid or provided before the entity has actual knowledge.

(4) When the person (to whom the services relate) is an Employee who is laid off or retired, or is a Dependent of such an Employee, the benefits of the other dental care coverage shall be determined before those of this Agreement. lf the other dental care coverage does not have this rule, and if, as a result, there is no agreement between this Agreement and the other dental care coverage on the order of benefits, this rule is ignored.

(5) If the individual is covered under two dental care programs when none of the above applies, the benefits of the plan which has covered the individual for the longer period of time shall be determined first.

(6) All benefits payable under compulsory No-Fault Automobile Acts shall be subject to this COB provision.

4. For the purpose of this provision, the Plan may, without consent or notice to any Member, release to or obtain from any insurance company or other organization or person, any information which may be necessary regarding coverage, expense and benefits.

5. Any Member claiming Benefits under this Agreement must furnish the Plan such information as may be necessary for the purpose of administering this provision.

6. Overpayment - In the event the Plan provides Benefits to the Member in excess of the amount which would have been provided by reason of coverage under another dental care coverage, the Plan shall be entitled to recover the amount of such excess from one or more of the covered Members.

Note: A dental care coverage which provides benefits in the form of services may recover the reasonable cost value of providing those services, if applicable under the above rules, to the extent that Benefits are not covered services and have not already been paid or provided by this Agreement.

Workers' Compensation Exclusion

Expenses for which payment is required under applicable Workers' Compensation statutes are not eligible for payment under this Agreement. This Agreement is not in lieu of and does not affect any requirement for coverage by Workers' compensation insurance.

Third Party Liability

In the event a covered Member sustains any illness or injury for which a third party may be responsible, the following provisions apply.

A. Recover Rights - Up to the amount of Benefits paid in connection with the illness or injury, the Plan shall be entitled to the proceeds of any settlement or judgment which results in a recovery from the third party; but only under the conditions that the covered Member is primary, and the Plan is secondary.

B. If the Plan requests, the Member shall hold the rights of recovery against the third party in trust for the Plan up to the amount of Benefits paid or provided in connection with the illness or injury.

C. The Plan shall pay out of such proceeds actually recovered a proportionate share of any reasonable expenses incurred in effecting collection from the third party or his/her insurer.

D. Receipt by the covered Member, or on behalf of the covered Member, of any Benefits in connection with an illness or injury shall constitute the Member's unconditional agreement to each and all of the provisions set forth in this ARTICLE Ill.

ARTICLE IV
COVERED DENTAL SERVICES AND CO-PAYMENTS

Schedule of Benefits and Co-payments

A Schedule of Benefits and Co-payments applicable to this Total Care Plan and under this Agreement is attached hereto. The Schedule of Benefits and Co-payments lists all covered dental services. All Co-payments shall be payable by the Subscriber or Subscriber's covered Dependents directly to the designated Plan Provider and neither the Plan nor the Group shall have any liability for the collection thereof.

Specialty Care

Should a Member require dental care from a specialist, the Plan Provider will, depending on the plan of coverage (as provided in the Schedule of Benefits and Co-payments), refer the Member to a participating specialist or will initiate Plan authorization for Member referral to a participating specialty. Specialty care benefits are available only from participating specialists.

Emergency Care

A. When a covered Member is less than fifty (50) miles from his or her Plan Provider, the Member should always attempt to obtain Emergency Care from their Plan Provider FIRST.

B. When a Member seeks Emergency Care during normal business hours and the member's selected Plan Provider is not accessible, the Member should contact the Plan for assistance at (801) 273-3352 or 1 -800-880-3536.

C. When a Member's Plan Provider is not accessible and after the Member has made a reasonable attempt to contact the Plan for assistance or a Member is more than fifty (50) miles from his/her Plan Provider, then the Member should seek Emergency Dental care for the relief of pain, bleeding or swelling from any licensed dentist. Under such circumstances, the Plan will pay up to a maximum of $50.00 per contract year per person. A written, itemized statement for these services must be presented to TDAUT for reimbursement. If it is necessary to have additional treatment, it must be done by the Member's Plan Provider in order for benefits under this Agreement to be applicable.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

Principal Exclusions and Limitations of Benefits

1. Prophylaxis is limited to one every six (6) months.
2. Fluoride application is limited to one per year to age fifteen (15).
3. Supplement bitewing x-rays are limited to one series of four films in any six (6) consecutive months.
4. Complete mouth or panorex x-rays are limited to once every thirty-six (36) months.
5. Sealants are covered to the age of seventeen (17) and are limited to permanent molars only.
6. Periodontal treatment(sub-gingival curettage and root planing) are limited to five quads in any twelve (12) consecutive months.
7. Replacement of a restoration is covered only when it is dentally necessary.
8. Oral examinations are limited to twice in any period of twelve (12) consecutive months.
9. Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
10. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
11. Full upper and/or lower dentures are not to exceed one each in any five (5) year period. Replacement will be provided by the Plan for an existing full or partial denture only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
12. Denture relines are limited to two (2) in any year.
13. Services for injuries or conditions which are covered under Workers' Compensation or Employers' Liability Laws.
14. Services which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
15. Temporomandibular joint treatment (TMJ), except as provided herein.
16. Elective or cosmetic dentistry, except as provided herein.
17 Oral surgery requiring the setting of fractures or dislocations. Orthonognathic surgery or extractions solely for orthodontic purposes.
18. Treatment of malignancies, cysts or neoplasms or congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
19. Dispensing of drugs.
20. Hospital charges of any kind.
21. Loss or theft of dentures or bridgework.
22. Any procedure of implantation or of an experimental nature.
23. General anesthesia or IV/conscious sedation.
24 Services that cannot be performed because of the general health, physical or behavioral limitations of the patient.
25. Fees incurred for broken or missed appointments (without 24 hours notice) are the Member's responsibility.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

Principal Exclusions and Limitations (Cont.)

26. Dental expenses incurred in connection with any dental procedure started prior to the effective date of coverage.
27. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
28. Any procedure performed for the purpose of correcting contour, contact or occlusion. Any procedure to correct tooth structure lost due to attrition, erosion or abrasion.
29. Any procedure that is not specifically listed as a covered benefit.
30. Provider may refuse treatment to any patient who continually fails to follow a prescribed course of treatment.
31. Any dental treatment which, in the opinion of the Plan's dental consultant has a poor prognosis.
32. Nightguard (occlusal guard) limited to one each twelve (12) months.
33 Services performed by a dentist who is not a Participating Dentist , except for emergency care as provided herein.
34. Partial dentures are not to be replaced within any five (5) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

Orthodontic Plan Exclusions and Limitations

1. No benefits will apply for a treatment program which began before the Member/Subscriber enrolled in the Orthodontic Plan.
2. No benefits will apply for lost or broken appliances.
3. Extractions are not included as a benefit.
4. Additional fees, for which you are responsible, may be charged by the dentist for:
   a. Care required in excess of 24 months from the time of banding.
   b. Gross non-cooperation.
   c. Accidents occurring during the period of treatment.
   d. Cases involving surgical orthodontics.
   e. Cases involving myofunctional therapy of TMJ.
5. If the Member and/or Subscriber relocates to an area and is unable to receive treatment from a member Orthodontist, coverage under the Plan ceases and it becomes the obligation of the Member and/or Subscriber to pay the usual and customary fee of the Orthodontist where the treatment is completed.
6. Choice of an Orthodontist is limited to Orthodontists participating in the Plan or to Orthodontists who will accept the fees outlined in the Plan.
7. If the Member and/or Subscriber becomes ineligible for benefits under this Plan for treatment, coverage under the Plan ceases and it becomes the obligation of the Member and/or Subscriber to pay the remaining balance due the Orthodontist

ARTICLE VI
GENERAL PROVISIONS

A. Any notice that the Plan is required to submit to the Group will be considered delivered if mailed to the Group at the address appearing on the records of the Plan. The Plan may submit notices, including individual identification cards and booklets or notifications of modification thereto, to Members by the same means. The Group agrees to receive and deliver all notices on behalf of the Members.

B. No person other than an enrolled Member shall be entitled to receive any benefits under this Agreement. Such right to receive benefits may not be transferred or assigned.

C. The services provided under this Agreement are at all times subject to availability of dental facilities and the ability of Dentists and other providers to furnish services. The Plan assumes no liability for conditions beyond its control which makes it impossible for services provided under this Agreement to be obtained, such as:

1. Epidemics:

2. Natural disasters;

3. Civil disorders;

4. War; or

5. Labor disputes.

D. All Plan Providers (Dentists) furnishing services to a Member do so as independent contractors. TDAUT shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by a member while receiving such services.

E. All Co-payments and any additional fees or charges provided hereunder are due to the Plan Provider or dental center immediately upon commencement of extended treatments or upon performance of services for which such fees or charges are specified under the Schedule of Benefits and Co-payments attached hereto. Termination of the Agreement shall in no way affect or limit any liability or obligation of the Subscriber to the Plan Provider or dental center for any such fees or charges owing.

F. If a Subscriber fails to indicate a preference for a Plan Provider or dental center within ten (10) days prior to the effective date of coverage, IDA may assign the Subscriber and any enrolled Dependents to a Plan Provider or dental center.

G. The Subscriber is solely responsible for payment of eligible dental services received by the Subscriber or the Subscriber's Dependents from a Plan Provider or dental center that was not selected in writing by the Subscriber or for which a prior written referral by the selected Plan Provider has not been made.

H. While employed with the Group, the Subscriber agrees to remain enrolled as a Member of the Group Dental Plan for a minimum of one year. Less than one year membership may result in the Subscriber being billed usual service fees minus premium and Co-payments paid.

ARTICLE VI
GENERAL PROVISIONS

I. The Group shall furnish the Plan with a complete list of all eligible Subscribers and Dependents together with completed application forms therefore, at least fifteen (15) days prior to the effective date of this Agreement. Thereafter, the Group shall notify the Plan of all additions and deletions on a monthly basis no later than fifteen (15) days prior to the first of the following month.

J. This Agreement, including any endorsements and riders issued hereunder, constitutes the entire contract between the parties. No authorized or unauthorized representations, promises, or statement, including those in advertising and promotional material, made by TDAUT employees or agents that differ in any way from the terms of this Agreement and the Member's Booklet/Certificate shall be given any force or effect. In the event of any inconsistency between the terms of this Agreement and the Member's Booklet/Certificate, the terms of this Agreement shall prevail.

TDAUT has caused this Agreement to be signed as of the effective date hereof.

X Group:	Total Dental Administrators of Utah (TDAUT)
X By: _____	By: _____
X Signature: _____	Signature: _____
X Title:_____	Title: _____
X Date:_____	Date: _____