

APPLICATION
Benefit Control Methods Discount Dental Program
Discount Medical Plan



www.bcm-dental.com

Please complete this application and return:

1. Via Fax: (240) 283-3595 ... or ... 2. By Mail: BCM Discount Dental Program,
111 Rockville Pike, Suite 950, Rockville MD, 20850

STEP ONE: PERSONAL INFORMATION

| | | |
|---|--------------------|-------------------------|
| LAST NAME | FIRST NAME | DOB |
| STREET ADDRESS: | | CITY, STATE, ZIP |
| HOME PHONE: | WORK PHONE: | EMAIL ADDRESS: |
| OTHER HOUSEHOLD MEMBERS (IF INCLUDED): | | |
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |
| 4. _____ | | |

NOTE: To make changes or additions to your membership, please call Customer Care toll free at 1-866-498-7914.

PROGRAM OFFERING*:

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|--|
| DENTAL DISCOUNT PROGRAM \$69 ANNUAL |
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*Membership can include up to 9 total persons residing at the same address or students in college.

STEP TWO: BILLING INFORMATION – *Processing will be delayed on applications received without a form of payment*

I will pay by:

| |
|--|
| Credit Card – Mark one: <input type="checkbox"/> Visa <input type="checkbox"/> Master Card Name as it appears on Card Name: _____ Card Number: _____ Exp. Date: _____ <input type="checkbox"/> Money Order* <input type="checkbox"/> Personal Check* |
|--|

* Please make check or money order payable to: GDS-MD.

Applicant's Signature: _____ **Date:** _____