qcd DENTAL BENEFITS

Please complete all information and sign. Please print all information.

SUBSCRIBER INFORMATION

☐ New QCD Member ☐ Existing QCD Member making changes

Last Name	First Name	MI	Date of Birth
Address	City	State	Zip
Social Security Number	Telephone		
Company Name	Effective Date	Hire Date	

COVERAGE SELECTED

☐ Employee Only	No Charge
☐ Employee and One Dependent	$8 / Month
☐ Employee and Family	$12 / Month

DEPENDENT INFORMATION

Social Security Number	Last Name	First Name	MI	Date of Birth	Gender	Relationship

I hereby make application for membership in QCD of America® (QCD). I agree to hold QCD harmless from any liability for negligence on the part of the Affiliated Dentist. I further release QCD from and waive any claims for negligent referral, negligent certification or similar claim. I hereby authorize my employer to make payroll deductions, if required, for the coverage selected. The QCD of America Dental and Vision Benefit Program is not an insurance plan and does not constitute insurance coverage.

Date _____ Applicant Signature _____