



PLEASE SELECT WHICH EMBLEMHEALTH DENTAL NETWORK(S) YOU WOULD LIKE TO JOIN.

Preferred Plus

Preferred

(which includes the Preferred Premier and
Dental Access plans, where applicable)

DENTIST

By signing below, I agree to participate in the Preferred Plus and/or Preferred EmblemHealth Plan, Inc. Dental networks and to be bound by all terms and conditions of the attached EmblemHealth Plan, Inc. Dental Preferred Plus and/or Preferred Dental Group Contract.

Signature:

Name/Title:

On Behalf of (if applicable):

Date:

Address:

Phone Number:

Fax Number:

Office Email Address:

DEA # (if applicable):

Tax ID:

FOR EMBLEMHEALTH USE ONLY

Signature:

Date: