

Dental Group Contract

Signature Page

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:	

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