

# Application for a Discount Medical Plan Harbor Dental Plan

Please complete this form and send to:  
**Harbor Dental Plan** Fax 713-668-4530  
**PO Box 1550**  
**Bellaire, TX 77402-1550**  
**1-800-284-0822**

**The Harbor Dental Plan is NOT health insurance. This discount card program contains a 30 day cancellation period.** The plan provides discounts at certain providers for dental services. The plan does not make payments directly to the providers of dental services. The plan member is obligated to pay for all services rendered but will receive a discount from those providers who have contracted with **Harbor Dental Plan, L.P.** Discount Medical Plan Organization: Newbn, Inc. 14240 Proton Rd, Dallas, TX 75244.

**Subscriber Information:**

|   |               |                |  |               |
|---|---------------|----------------|--|---------------|
| First Name  |               | Middle Initial | Last Name  |               |
| Address   |               | City           | State  | Zip           |
| Social Security Number  | Date of Birth |                | Employer Name  | Phone         |
| Day Phone   | Evening Phone |                | Employer Address   |               |
| How Did you hear about Harbor Dental Plan? Enter Promotional Code.  |               |                | Spouse Name  | Date of Birth |
| Type of Plan<br><input type="checkbox"/> Dental Only <input type="checkbox"/> Dental, Vision, Pharmacy & Chiropractic |               |                | Type of Membership<br><input type="checkbox"/> Member only <input type="checkbox"/> Member plus 1 dependent<br><input type="checkbox"/> Member plus 2 or more dependents |               |

**Total number of Dependents (including spouse):**

| 1) | Dependant Name | Date of Birth | Relationship |
|----|----------------|---------------|--------------|
| 2) | Dependant Name | Date of Birth | Relationship |
| 3) | Dependant Name | Date of Birth | Relationship |
| 4) | Dependant Name | Date of Birth | Relationship |
| 5) | Dependant Name | Date of Birth | Relationship |

|  |                                  |                                   |
|--|----------------------------------|-----------------------------------|
| <b>MEMBERSHIP OPTION:</b>  |                                  |                                   |
| Check boxes  | <input type="checkbox"/> Monthly | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Member only                                     | \$3.95                           | \$47.40                           |
| <input type="checkbox"/> Member plus 1 Dependent                         | \$5.95                           | \$71.40                           |
| <input type="checkbox"/> Member plus 2 or more Dependents                | \$7.95                           | \$95.40                           |
| <input type="checkbox"/> Additional Vision, Pharmacy & Chiropractic Care | \$3.95                           | \$47.40                           |
| <input type="checkbox"/> Monthly Plans have an annual Processing Fee     | \$9.00                           | Waived                            |
| <b>TOTAL AMOUNT:</b>   | <b>\$</b>                        | <b>\$</b>                         |

|   |          |
|---|----------|
| <b>METHOD OF PAYMENT:</b>   |          |
| <input type="checkbox"/> Check/Money Order/Cash <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard |          |
| Credit Card Number  | Exp Date |
| Card Holder Name  |          |

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Card Holder Signature \_\_\_\_\_ Date \_\_\_\_\_

By signing, I understand that membership is on an annual basis. I further agree to allow Harbor Dental Plan to automatically debit my credit card for the full annual payment or on a monthly basis, as I have indicated above, until such time as my enrollment has been cancelled. Personal check and Money Orders will also be accepted for the full annual payment, but they cannot be used for the monthly payment option.