



HOME CHILD CARE PROVIDERS
DIRECT ACCESS DENTAL PLAN ENROLLMENT FORM

mail this form to:
DIRECT ACCESS DENTAL PLAN
c/o SIDS
P.O. Box 9005
Lynbrook, NY 11563-9005

UFT-HCCP MEMBER LAST NAME _____ FIRST NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

INDIVIDUAL SUBSCRIPTION

FAMILY SUBSCRIPTION* (provide your family member information below)

FAMILY MEMBER'S NAME	RELATIONSHIP TO UFT-HCCP MEMBER	BIRTHDATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*YOUR UNMARRIED CHILDREN OVER AGE 23 REQUIRE INDIVIDUAL SUBSCRIPTIONS.

ENCLOSED IS A CHECK PAYABLE TO SIDS IN THE AMOUNT OF

\$36 INDIVIDUAL SUBSCRIPTION \$48 FAMILY SUBSCRIPTION

OR, CHARGE MY AMEX MC VISA DISCOVER

CARD No. _____ EXP _____ / _____

CARD BILLING ADDRESS _____ ZIP _____

SIGNATURE _____

MEMBERSHIPS EXPIRE ON DECEMBER 31ST REGARDLESS OF WHEN YOU ENROLL DURING THE YEAR.