DIRECT ACCESS DENTAL PLAN
c/o SIDS
P.O. Box 9005
Lynbrook, NY 11563-9005

SUBSCRIPTION FORM

SPONSOR *(UFT MEMBER)*

LAST NAME _________________________FIRST NAME ________________________SS No.______________________

DIRECT ACCESS DENTAL PLAN SUBSCRIBER

LAST NAME ____FIRST NAME_______________________________________

STREET ADDRESS _________________________________CITY______________________STATE_____ZIP__________

HOME PHONE No. (   )____________ ALTERNATE PHONE No.(   )______________

SUBSCRIBER'S RELATIONSHIP TO SPONSOR

ù SELF   ù CHILD   ù PARENT(S)   ù SPOUSE, DOMESTIC PARTNER   ùOTHER(specify)___________________

ù INDIVIDUAL SUBSCRIPTION*   ù FAMILY SUBSCRIPTION (complete below)

NAME	RELATIONSHIP TO SUBSCRIBER	DOB

*UNMARRIED DEPENDENT CHILDREN BEYOND AGE 19 WHO ARE NO LONGER IN FULL-TIME STUDENT STATUS; UNMARRIED DEPENDENT STUDENTS BEYOND AGE 23; AND PARENT(S) REQUIRE INDIVIDUAL SUBSCRIPTIONS.

ENCLOSED IS A CHECK PAYABLE TO SIDS IN THE AMOUNT OF

ù$36 INDIVIDUAL SUBSCRIPTION   ù$48 FAMILY SUBSCRIPTION

OR, YOU MAY CHARGE MY   ùAMEX   ù MC   ù VISA   ù DISCOVER

CARD No.__________________________________ EXP________/________

CARD BILLING ADDRESS______________________________ ZIP __________

SIGNATURE____