

CADP

CALIFORNIA ASSOCIATION OF DENTAL PLANS

MEMBERSHIP APPLICATION

Plan Information:

Name of Plan _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone __ (____) _____ FAX __ (____) _____

e-mail _____

Address _____ Website _____

Parent Company _____

Knox-Keene License # _____

Date Knox-Keene License Issued _____

Other State's Licensed to Operate _____

Number of Subscribers _____ Number of Members _____

Category of Membership:

_____ Full Member (Knox-Keene Licensed Plan)

_____ Associate Member (Non-Knox-Keene Licensed Plan or Organization)

_____ Individual Member (Individual Person)

Companies applying for full membership please specify who will have authority from your company to vote on Association matters:

Delegate _____ Title _____

Alternate _____ Title _____

Names and Titles of Key Company Executives:

President/CEO _____

Chief Operating Officer _____

Dental Director _____

Chief Financial Officer _____

Senior Marketing Director _____

Senior Provider Relations Director _____

Dues:

Dues are assessed annually. See Dues Structure for appropriate annual membership dues. Make check payable to CADP. Mail completed application to CADP, One Capitol Mall, Suite 320, Sacramento, CA 95814.

Approval:

All member applications must be approved by the Board of Directors.

Authorized Signature _____

Title _____ Date _____