

All information contained in this application will be considered confidential and only used for purposes of evaluating applicants for membership in DENTAL SELECT.

1. **Complete all parts of the attached form.**
2. All information should be clearly printed or typed.
3. If more information is needed, attach additional sheets and make reference to questions being answered.
4. Include your signature and date on the last page.
5. Attach copies of the following documents to this application:
 - a. Current Texas license to practice dentistry.
 - b. Narcotics registration certificate.
 - c. Professional liability insurance policy and certificate of coverage from insurance carrier.
 - d. Evidence of board status and/or added certificates of accreditation (if applicable).

PLEASE RETURN COMPLETED APPLICATION VIA MAIL OR FAX TO:

**Amanda Anderson
Phone (801) 313 - 7052
Fax (801) 386 - 5372**

**DENTAL SELECT
75 W. Towne Ridge Pkwy, Tower 2,
Suite 500, Sandy, UT 84070**

Professional Category – Check appropriate box

DMD DDS Other _____

Specialty – Check appropriate box

Oral Pedi Endo Perio Ortho Prosthodontist General

Provider Information

First Name	M.I.	Last Name	NPI
State License Number	License State	License Effective Date	License Expiration Date

Service Location

Office Name	Email Address						
Address							County
City	State					Zip	
Phone #	Fax #						
Federal Tax ID Number	Bus. NPI						
Languages Spoken							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening Time							
Closing Time							

Billing / Remit Check

Check box if this information is the same as above

Office Name	Email Address						
Address							County
City	State					Zip	
Phone #	Fax #						
Federal Tax ID Number	Bus. NPI						

Is the information the same? Yes No

Office Contact

First Name	Last Name	Email
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General Information – If the answer to any of the following questions is yes, provide a full explanation of details on a separate sheet and attach to this application.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been convicted of a criminal offense other than a minor traffic violation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any disciplinary actions/investigations by any state licensing board been initiated against you?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your license to prescribe or dispense controlled substances ever been denied, revoked, suspended, or restricted?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your participating provider status in any private, federal, or state dental insurance program been denied, revoked, restricted, subject to disciplinary action or probation or is in the process of being denied, etc.?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any academic appointment, institutional affiliations, professional society memberships or board verifications been denied, revoked, restricted, subject to disciplinary action or probation or is in the process of being denied, etc.?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been examined by any specialty board but failed to pass the examination?

Additional Office Information - Copy if additional space is needed

First Name	M.I.	Last Name	NPI				
State License Number	License State	License Effective Date	License Expiration Date				
Service Location							
Office Name		Email Address					
Address			County				
City		State	Zip				
Phone #		Fax #					
Federal Tax ID Number		Bus. NPI					
Languages Spoken							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening Time							
Closing Time							
Billing / Remit Check							
<input type="checkbox"/> Check box if this information is the same as above							
Office Name				Email Address			
Address						County	
City				State		Zip	
Phone #				Fax #			
Federal Tax ID Number				Bus. NPI			

Authorization to Release Confidential Information To Dental Select

By applying for participation in DENTAL SELECT, I hereby authorize DENTAL SELECT, its administrator and membership committee "authorized representatives" to communicate with the following associations/institutions with which I am currently associated (or have been associated in the past) who may have information bearing on my professional competence, character, and ethical qualifications.

- Texas STATE DENTAL ASSOCIATION or other state/county dental society.
- Texas Department of Business Regulation/Utah Dentist licensing board.
- Professional liability insurance carriers.
- Dental plans in which I am/have been a participating provider (including third party administrators/claims processor).
- Department of Health and Human Services.
- Peer review organizations.

I hereby further consent to the inspection by authorized representatives of DENTAL SELECT of all records and reports from associations/institutions as described above that may be material to an evaluation of my professional qualifications, competence, character and ethical qualifications for membership, including evaluations, complaints, claims, disciplinary action and/or recommendations.

I hereby release from liability all authorized representatives of DENTAL SELECT for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications.

I hereby release from liability any and all individuals and organizations who provide information to DENTAL SELECT and its authorized representatives, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for membership and I hereby consent to release of such information.

I understand and agree that I, as an applicant for membership in DENTAL SELECT, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications, and I understand that any misrepresentations in, or omissions from, this application that bear on my qualifications constitute cause for denial of membership. All information submitted by me in the application is warranted to be true and correct. I further agree to notify DENTAL SELECT of any change in status or other pertinent circumstances which occur during the evaluation of my application.

DATED this _____ day of _____, 20____.

Dentist's Signature

Dentist's Name (type/print)

Address City State Zip

PARTICIPATING GENERAL DENTIST AGREEMENT

THIS PARTICIPATING GENERAL DENTIST AGREEMENT is made and entered into by and between Select Benefits Group LLC, a Utah limited liability company doing business as Dental Select (“Dental Select”), and the dentist or dental entity identified below (“Dentist”). Dental Select and Dentist are collectively referred to herein as the “Parties” or individually as a “Party.” In consideration of the mutual covenants and promises set forth herein, Dental Select and Dentist agree as follows:

1. Background. Dental Select develops, maintains, administers, and at times leases, networks of licensed dental health providers (“Networks”). Dental Select provides access to its Networks to insurance carriers, employers, labor unions, plan sponsors, third party administrators, or other groups (“Payers”), which extend dental benefit plans (“Plans”) to persons who are entitled to receive benefits under one or more Plans (“Members”). Plans may be administered by Dental Select and may include, but are not limited to, discounted fee-for-service, insured, and self-funded group health plans. The parties desire to enter into this Agreement under which Dentist will be a participating provider in Dental Select’s Networks and provide dental services or dental supplies to Members. (For the purposes of this Agreement, a “participating” Network dentist or dental specialist shall have the same meaning as a “contracted” Network dentist or dental specialist.)
2. Dental Services. Dentist hereby agrees to (a) provide or arrange for the provision of dental care for members within the normal scope of Dentist’s dental practice; (b) make such dental care services available to Members, without limitation or discrimination, to the same extent as they are made available to both current and new patient of Dentist; and (c) exercise professional judgment in the diagnosis, treatment and care of Members.
3. Standard of Care.
 - (a) The Dentist represents and warrants that all services rendered under this Agreement will conform to the accepted practices and standards prevailing in the applicable professional community at the time services are rendered. Nothing contained in this Agreement will (i) increase, alter or otherwise modify the standard of care for Dentist’s services under applicable law; or
 - (ii) limit Dentist’s ability to advise his/ her patients fully about treatment options or other issues that affect the health care of Dentist’s patients.
 - (b) Dentist agrees to practice within the scope of his/ her licensure under applicable state laws governing the practice of dentistry. Dental Select does not practice dentistry and has no right to direct the treatment of Members. To the extent Dental Select determines a procedure to be a Covered Service or medically necessary under a Plan’s provisions, such determinations are not a substitute for Dentist’s professional judgment. Dentist is responsible to render appropriate dental care to Members who are under his/ her care, independent of Dental Select’s benefit coverage determinations.
 - (c) Dentist agrees to accept and be solely responsible for the quality of his/ her services provided to Members, and his/ her acts and omissions related to diagnosis and treatment of Members.
4. Certificate/ License/ Credentialing. Dentist represents and warrants, as of the date hereof and at all times during the term of this Agreement, that (a) he/ she is duly licensed to practice in each and every state in which he/ she renders services under this Agreement, (b) she/ he has not been convicted of a criminal offense (other than a misdemeanor traffic violation), has not been suspended or terminated from providing services to Medicaid or Medicare patients or otherwise barred from contracting with the federal or any state government, and has not had any of his/ her licenses, certificates, including controlled substance registration certificate issued by the Drug Enforcement Administration, and/ or professional privileges restricted, revoked, suspended or otherwise terminated, (c) he/ she is not aware of any situation which would adversely affect his/ her ability to perform services under this Agreement and (d) all information provided by Dentist in connection with Dental Select’s credentialing and re-credentialing processes have been, will be and are true, correct, complete and non misleading. Dentist hereby agrees to comply with Dental Select’s policies for Network participation, including cooperation with Dental Select’s credentialing and re-credentialing processes and procedures, including but not limited to, utilization review, peer review, grievance and appeal, and any other reasonable policies that Dental Select may implement. Dentist will immediately notify Dental Select in writing of the instigation of any disciplinary proceedings against or forfeiture of the license held by Dentist.

5. Claims. The Dentist will bill Dental Select or the designated Payer, using the most current American Dental Association (ADA) claim format and according to the most current edition of the CDT, within ninety (90) days or as set forth in applicable law, whichever is less, of the date of service. Dental Select may deny payment of any claim submitted more than ninety (90) days after the date Covered Services were rendered, unless applicable State law provides otherwise.
6. Benefit/ Eligibility Verification. The Dentist will contact Dental Select for eligibility verification and benefit information prior to the delivery of Covered Services. Dentist understands that a Member's identification card is not a guarantee that the cardholder is a Member in good standing.
7. Payment for Services.
 - (a) As used herein, "Covered Services" means dental care services for which a reimbursement is available under a Member's Plan, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation. Services that may otherwise be medically necessary may not be Covered Services if they are excluded or otherwise limited from coverage by the Member's Plan.
 - (b) Dentist shall be paid, in exchange for medically necessary Covered Services provided by Dentist to Members, according to the Allowed Fee established under the Plan's applicable Network's Fee Schedule, Plan provisions, and in accordance with methodologies and standards prevailing in the industry; provided, that in no event shall Dentist be paid in excess of Dentist's usual and customary charges.
 - (c) Services rendered or items furnished to Members by Dentist which are not Covered Services under the Member's Plan, and all co-payments, co-insurance and/ or deductibles, shall be paid by Member and Dentist is responsible for collection of all such payments.
 - (d) Dental Select shall have no obligation to Dentist for any claims not paid by or on behalf of a self-funded group plan sponsor
 - (e) For certain dental services, and only where so indicated on a Fee Schedule, the Dentist agrees to charge the Member the lesser of the amount indicated for such services on the fee schedule, or, the Dentist's normal billed charges unless otherwise prohibited by applicable state law.
8. Billing Members. Dentist agrees accept the applicable Allowed Fee (or the Dentist's usual fee, if less) as payment in full for Covered Services provided to Members. Dentist agrees to apply the appropriate Fee Schedule in accordance with the Member's Plan, regardless of whether a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other contractual limitation has been met or applies. Except as provided in subparagraph (a), the Dentist shall not, under any circumstances, including the insolvency of Dental Select or any Payer, bill Members for the balance, if any, between the Dentist's usual charges and the Allowed Fee amount.
 - (a) Services rendered or items furnished to Members by Dentist which are not Covered Services (including services and items provided under the Silver Network discount program, if applicable), and all co-payments, co-insurances and/ or deductibles, shall be paid by Member and Dentist is responsible for collection of all such payments.
9. Participating Provider Designation. During the term of this Agreement, Dental Select shall have the right to designate Dentist as a Dental Select "participating" or "contracted" dental provider (or words of similar meaning), as to one or more Plans or Networks, and to make public reference to such designation. Such designation and reference may include the name, specialty (if any), address, and telephone number of Dentist. Except as otherwise provided in this Agreement, neither party shall use the other's name, symbol, logo, or service mark without the other party's express prior written consent.
10. Referrals. The Dentist will make a good faith effort to use or refer Members to other dentists or specialists who participate in Dental Select's Networks (except in cases of emergency or when no contracted Network provider is available). If the Dentist elects to refer a Member to a non-contracted dentist or specialist, the Dentist agrees to inform the Member that said dentist or specialist is not a contracted Network provider.
11. Coordination of Benefits. Dentist shall cooperate with Dental Select in the implementation of coordination of benefits policies. Dentist agrees to make reasonable efforts to determine if a Member is covered under a health insurance plan in addition to his/ her Plan, or if the requested services are covered under workers compensation programs, automobile, or other insurance. In the event the Member or services rendered to a Member are covered under any such plan of insurance ("Other Insurance"), Dentist shall

submit a claim to Dental Select for coverage under Member's Plan only if (a) the Member's Plan, rather than the Other Insurance, is the primary payer, or (b) Dentist has received from the Other Insurance an explanation of benefits or other statement of payment or non-payment. Any payment or reimbursement received from Other Insurance shall be credited to reduce the amount payable to Dentist under this Agreement. In the event the Member's Plan is primary under applicable coordination of benefit rules, the Plan shall pay the amounts due under this Agreement. In the event the Member's Plan is other than primary under the coordination of benefit rules, the Plan shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to the Plan's maximum liability under the terms of this Agreement. In any event, the total paid by all sources will never exceed the Allowed Fee applicable to the Member's Plan.

12. Medical Records. Dentist shall maintain records on each Member treated by Dentist as required by law, and in accordance with prudent record-keeping practices, which records shall be retained by Dentist for six (6) years following the date the Member ceases to be under the care of Dentist or such longer period as may be required by applicable law. If claims are submitted electronically, the recordkeeping period shall begin to run on the date after the Dentist submits the last claim under this Agreement. With the proper patient consent (if required) and in accordance with all local, state and federal laws governing confidentiality (including the terms, conditions and requirements of the Health Insurance Portability and Accountability Act of 1996 and rules and regulations adopted thereunder ("HIPAA"), Dentist shall furnish, upon request and without charge, to Dental Select and/ or Plan, copies of all medical or patient records as may be reasonably necessary for administration of applicable Plans, "payment" of claims or other "health care operations" (as such quoted terms are defined under HIPAA)
13. Term; Termination.
 - (a) The term of this Agreement shall begin on the date this Agreement is executed by the Dentist and shall remain in effect until terminated by either party pursuant to the terms herein described.
 - (b) This Agreement may be terminated without cause by either party by giving the other party thirty (30) days prior written notice delivered by certified mail, postage prepaid, addressed to the other party at its current address.
 - (c) Dental Select may terminate this Agreement at any time for immediate cause for any of the following reasons: (i) Dentist's license is revoked, suspended, restricted, (ii) the Dentist's professional liability insurance is terminated or restricted, (iii) Dentist has limited services or discriminated in providing dental services to Members in violation of this Agreement, (iv) any breach or falsity in any of Dentist's representations or warranties in Section 4 above, (v) Dentist has submitted false or misleading claims to Dental Select, or (vi) Dentist has committed a felony or other acts involving moral turpitude, dishonesty or fraud.
 - (d) This Agreement may be terminated at any time by mutual agreement of the parties.
 - (e) If this Agreement is terminated, each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to termination. Except when termination occurs pursuant to paragraph 13(c), above, Dentist agrees to continue to provide dental care to Members that began prior to termination of this Agreement until such treatment is completed. It is the Dentist's responsibility to notify (and decline, if applicable) any new Members or Members who are existing patients of record. Dental Select may (but is not required to) notify some or all Members that Dentist is no longer a participating Dental Select provider.
14. Professional Liability Insurance. The Dentist agrees to maintain policies of malpractice and other insurance, as necessary, to ensure the Dentist and his/her employees are covered against any claims for damages. The amounts and extent of the insurance coverage shall not be less than \$100,000 per occurrence and \$300,000 in the aggregate. Further, the Dentist agrees to provide Dental Select or other designate, with certificates, or proof of insurance, and immediate notice of any change thereof.
15. Offsets; Payment Corrections; Right of Recovery. Dentist shall immediately notify Dental Select of overpayments and of payments to which Dentist is not entitled and refund to Dental Select all duplicate or erroneous claim payments regardless of the cause. In lieu of a refund and in accordance with applicable law, Dental Select may offset future claim payments due Dentist. Dental Select shall correct and pay to Dentist, from Plan funds as to which Dental Select is authorized to pay claims from, all underpayments of amounts due under this Agreement regardless of the cause. This Section 15 shall survive termination of this Agreement.
16. Confidential & Proprietary Information. The parties agree to keep the confidential and proprietary information or trade secrets of each other (including, but not limited to, compensation arrangements between the parties, Fee Schedules and

Allowed Fees established for Dental Select's Network(s), the Dentist's usual and customary charges, and the identities of the Members) in trust and confidence and agree that such information shall be used solely for the purposes contemplated in this Agreement.

17. Miscellaneous Provisions.

- (a) Notwithstanding anything to the contrary in this Agreement, Dentist acknowledges and agrees that: (i) Dental Select acts solely in the capacity of third party administrator on behalf of the Plans relative to claims for Covered Services; (ii) Dental Select is not, and shall not be, responsible or liable for the cost of any services provided to Members by Dentist or for the payment of any claim to Dentist, except for payment of claims for Covered Services from Plan funds as to which Dental Select is authorized to pay claims from; and (iii) the benefits, terms and conditions of the various Plans may be changed during the term of this Agreement without notice.
- (b) Nothing in this Agreement, or any written material or correspondence of Dental Select, shall be deemed or construed to create between Dental Select and Dentist any relationship of joint venturers, employer/ employee or principal/ agent. In performing services under this Agreement, Dentist shall act at all times and in all respects as a contractor entirely independent of Dental Select or any Plan, and Dentist is, and shall be, solely responsible for all services or supplies furnished by Dentist.
- (c) Except as otherwise provided herein, Dental Select retains the right to amend this Agreement, the Fee Schedules (and Allowed Fee amounts and Covered Services designated therein) established for Dental Select's Network(s), or any other provision, attachment or amendments to this Agreement, by making a good faith effort to provide notice to Dentist at least thirty (30) days in advance of any such amendment's effective date. If Dentist elects to not accept the amendment, Dentist has the right to terminate this Agreement by providing written notice of termination in accordance with paragraph 17(k). Dentist agrees that failure to provide notice of termination to Dental Select constitutes acceptance of the amendment by the Dentist, and such amendment shall not require a separate signature in order to be effective.
- (d) Dentist shall indemnify, defend, and hold Dental Select and each Plan, and their respective officers, directors, employees and agents harmless from and against any claim, loss, damage, cost, expense (including reasonable attorneys' fees) or liability arising out of or related to any acts or omissions of Dentist in connection with the diagnosis, treatment or care of Members.
- (e) This Agreement is non-exclusive and does not obligate Dental Select to require any Plan or Member to use Dentist's services. Dentist may contract with other insurance companies, health maintenance organizations, or preferred provider organizations. Dental Select may contract with other health care providers or provider organizations. Dentist acknowledges that Dental Select does not promise or otherwise guarantee any particular volume of referrals of Members to Dentist.
- (f) This Agreement shall not confer any rights or remedies upon any person other than Dental Select and Dentist and their respective successors and permitted assigns.
- (g) This Agreement (and the documents referred to herein) constitutes the entire agreement between the parties and supersedes any prior understandings, agreements, or representations by or between the parties, written or oral, to the extent they relate in any way to the subject matter hereof.
- (h) This Agreement shall be binding upon and inure to the benefit of the parties named herein and their respective successors and permitted assigns. Neither party may assign either this Agreement or any of its rights, interest, or obligations hereunder without the prior written approval of the other party; provided, however, that Dental Select may (i) assign all of its rights and interests, and delegate all of its duties, hereunder to a corporation, limited liability company or other legal entity which is wholly-owned by Dental Select (in which case Dental Select shall remain responsible for the performance of all its duties hereunder); (ii) assign all of its rights and interest and delegate all of its duties, hereunder to any successor corporation, limited liability company or other legal entity in connection with the sale, assignment or transfer of all or substantially all of its business and assets (in which case Dental Select shall be relieved of responsibility for the subsequent performance of the duties hereunder by such successor); or (iii) lease its participating provider network(s) in whole or in part, but only if the leasing entity pays participating providers in accordance with the Fee Schedules and other general payment policies set forth herein.
- (i) Provisions of this Agreement which, by their nature or purpose, are normally intended to survive expiration or termination of this Agreement, such as but not limited to Dentist's right to compensation for Covered Services rendered to Members prior to the date of expiration or termination and related claims submission and billing requirements and restrictions (§§ 5 - 7, 11), medical record provisions (§12), professional liability insurance requirements (§14), and Dentist's duty to indemnify, defend and hold harmless Dental Select and relevant Plans (§17(d)), shall survive any expiration or termination of this Agreement.

- (j) The Section headings contained in this Agreement are inserted for convenience only and shall not affect in any way the meaning or interpretation of this Agreement.
- (k) All notices, requests, demands, and other communications hereunder shall be in writing. Any notice, request, demand, or other communication hereunder shall be deemed duly given (i) when delivered personally to the recipient, (ii) one (1) business day after being sent to the recipient by a nationwide overnight courier service (charges prepaid), (iii) one (1) business day after being sent to the recipient by facsimile transmission or electronic mail, or (iv) four (4) business days after being mailed to the recipient by certified or registered mail, return receipt requested and postage prepaid, in each case addressed to the last known business address or facsimile number of the intended recipient. All notices to Dental Select shall be further addressed to: Provider Relations Department. Either party may change the address or facsimile number to which notices, requests, demands, claims and other communications hereunder are to be delivered by giving the other party notice in the manner herein set forth.
- (l) If any provision of this Agreement is held to be illegal or otherwise to conflict with any present or future insurance law or regulation, the parties shall use best efforts to amend the Agreement so as to eliminate the conflict or illegality, and the remaining provisions of this Agreement shall not be affected thereby and shall be enforceable without regard thereto.
- (m) This Agreement shall be governed by and construed in accordance with the domestic laws of the State in which Dentist maintains its principal place of business as of the date hereof.

18. Group Practice. If the Dentist is a group practice ("Group Practice"):

- (a) The Group Practice assumes all the duties, obligations, and responsibilities of Dentist as described herein, and shall require its staff of dental care providers to comply with the same.
- (b) All payments for Covered Services provided to Members treated at the Group Practice shall be paid to the Group Practice, under this Agreement. Dental Select shall have no responsibility to any dental care providers associated with the Group Practice beyond paying the Group Practice the compensation provided by this Agreement.
- (c) The Group Practice represents, warrants, and covenants that it has the unqualified authority to bind its staff of dental care providers to the terms of this Agreement. Dental Select reserves the right to restrict practice of one or more dental care providers in the Group Practice that are found to be in breach of this Agreement.

19. Network Participation. Dentist agrees to participate in each of the Network(s) that have Dentist's initials, where indicated, next to the listed Network(s). For Covered Services provided to Members enrolled in a Plan that is supported by a Network in which Dentist participates, Dentist agrees to provide services and accept compensation in accordance with the maximum allowable charge ("Allowed Fee") established under the schedule of fees ("Fee Schedules") for such Network(s) in accordance with this Agreement. Dental Select reserves the right to change Allowed Fee amounts at any time upon notice to the Dentist. (Instructions to Dentist: Initial the line next to the Network(s) in which you agree to participate, and sign where indicated below.)

- _____ Silver Network (This is a discount program - available in Texas and Utah only)
- _____ Gold Network
- _____ Platinum Network

20. Silver Network Discount Program (Available in Texas and Utah Only). Dentist acknowledges that the Dentist has the option, in the Dentist's sole discretion, to participate or not to participate in the Silver Network that provides discounts for services that are not covered by insurance or other third party reimbursement. Dentist acknowledges Dental Select has not restricted in any manner the choice of the Dentist to participate or not to participate in the Silver Network discount program. If the Dentist chooses to participate in the Silver Network discount program, Dentist may cancel such participation at any time by providing written notice to Dental Select. Dental Select will not take any action against Dentist based on the Dentist's decision not to participate (or to cancel participation) in the discount program.

BY SIGNING BELOW, the Dentist acknowledges having read and understood this Agreement, the Dentist agrees to participate with the Network(s) so indicated in Section 19, and agrees to the terms of this Agreement and has executed the same on the date so indicated.

Dentist Name (Please Print)

Dentist Signature

Address, City, State, Zip Code

SSN# or Tax ID#

Date Signed (Effective Date)

ACCEPTED BY DENTAL SELECT:

Printed Name of Authorized
Signatory

Authorized Signature

75 W Towne Ridge Pkwy
Tower 2 Ste 500
Sandy, UT 84070
Tel. 801.313.7052
Fax 801.386.5372

Please mail or fax completed Application, signed copy of this Agreement, and the W9 form to:

**DENTAL SELECT
ATTN: Provider Relations Department
75W Towne Ridge Pkwy
Tower 2 Ste 500
Sandy, UT 84070
Tel. 801.313.7052
Texas Fax: 801.386.5372**

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,