WESTERN DENTAL SERVICES, INC.
Group Subscriber Agreement
Cover Page
(This Cover Page is an integral part of the Group Agreement.)

Group Name:

Group Address:

Billing Address (if different than Group Address):

Group Contact Name & Title:

Contact Phone Number:

Monthly Prepayment Fees:

Subscriber Only:	**$**
Subscriber & One Dependent	**$**
Subscriber & Two or more Dependents	**$**

Group Contribution Level:

Subscriber Only:	**$________or _______%**
Subscriber & One Dependent	**$________or________%**
Subscriber & Two or more Dependents	**$________or ________%**

Schedule of Benefits Type:

Billing Terms:________________

Contract Terms:

Effective Date – 12:01 a.m. local time on 1, 20

Renewal Date -12:01 a.m. Local time on 1, 201

Initial Term: years
Subsequent Renewal Term: ________ years

Executed at _____ ______________ California, this ____ day of ________, 20____.	Executed at Orange, California, this ____ day of ________, 20___.
______________________________ ORGANIZATION (NAME)	WESTERN DENTAL SERVICES, INC.
By____________________________ Signature of Officer, Partner, Proprietor	By____________________________ Western Dental Authorized Signature
______________________________ Name	____________________________________ Name

WESTERN DENTAL SERVICES, INC.
Group Subscriber Agreement

THIS GROUP SUBSCRIBER AGREEMENT ("Group Agreement") by and between WESTERN DENTAL SERVICES, INC. ("Plan") and the employer, association, or other entity identified by "Group Name" on the Cover Page ("Group") is effective on the date indicated on the Cover Page, and is made with reference to the following facts:

A. Plan is a California corporation, licensed as a specialized dental health care service plan by the California Department of Managed Health Care, whose primary purpose is to provide dental health care services.

B. Group desires to obtain the dental services as described in this Group Agreement for and on behalf of its Eligible Participants as defined herein.

NOW, THEREFORE, Plan and Group (the "Parties") do mutually covenant and agree as follows:

I. DEFINITIONS

When capitalized in this Group Agreement, the following terms have the meanings set forth below. Where a capitalized term in this Group Agreement is not defined below, that term has the meaning as defined in the Evidence of Coverage Booklet.

A. "Benefit Plan" means those Benefits and Coverages, Exclusions, Limitations, Copayments and other terms as set forth in this Group Agreement, the Evidence of Coverage Booklet, and Schedule of Benefits.

B. "Cover Page" means the Group Agreement Cover Page which is attached to and incorporated into the Group Agreement by this reference.

C. "Dependent" means the spouse and children of an Eligible Participant.

D. "Eligible Participants" means Group employees, participants, or beneficiaries, and their Dependents, who are eligible to enroll as Members of the Benefit Plan under the eligibility requirements established by Group.

E. "Evidence of Coverage Booklet" means the Combined Evidence of Coverage and Disclosure Form distributed to Members upon enrollment which outlines the Benefits and Coverages, Exclusions, Limitations, and other terms and conditions of coverage under the Benefit Plan.

F. “Exclusion” means any provision of the Evidence of Coverage Booklet or Schedule of Benefits whereby coverage for a specified condition or treatment is entirely eliminated.

G. “Limitation” means any provision other than an Exclusion that restricts coverage under the Evidence of Coverage Booklet or Schedule of Benefits.

H. “Member” means an Eligible Participant who is actually enrolled in Plan.

I. “Prepayment Fee” means the amount payable per Member to Plan each month on a prepayment basis to obtain benefits provided under this Group Agreement.

J. “Schedule of Benefits” means the schedule of benefits and copayments applicable under Group’s chosen Benefit Plan.

K. “Subscriber” means the individual enrolled in the Plan for whom the appropriate Prepayment Fee has been received by Plan, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

II. BENEFITS, EXCLUSIONS, LIMITATIONS, CO-PAYMENTS, AND OTHER TERMS OF COVERAGE

The Plan and Group agree that Plan shall provide coverage to Members for the dental services described in the Benefit Plan under the terms and conditions set forth in the Evidence of Coverage Booklet and Schedule of Benefits, which are attached to this Group Agreement and incorporated herein by this reference.

III. ELIGIBILITY AND ENROLLMENT

A. Group shall determine who are Eligible Participants and who are Members actually enrolled in the Benefit Plan, and the Plan shall have the right to rely on that determination. Any disputes or inquiries by Members or Eligible Participants regarding eligibility, including rights regarding renewal, reinstatement and the like, shall be referred by the Plan to Group, which shall then advise the Plan of its determination. Group shall pay applicable Prepayment Fees pursuant to Article VI of this Group Agreement for each employee that Group determines is a Member.

B. An Eligible Participant must enroll in the Benefit Plan within 31 days of the date Eligible Participant becomes eligible or during the Group’s annual open enrollment period.

C. Group shall provide a written notice and certification, prepared by the Plan, to Eligible Participants at the commencement of the Group’s open enrollment period, which shall provide notice of the availability of coverage under the Benefit Plan and indicate that an Eligible Participant’s

failure to elect coverage, on his or her behalf or on behalf of his or her Dependents during the open enrollment period, permits the Plan to exclude coverage for a period of twelve (12) months **until Group's next open enrollment period** . Group shall require any Eligible Participant declining coverage under the Benefit Plan on behalf of himself or herself or any Participant's Dependent, to certify on the written notice and certification, the reason for declining coverage under the Benefit Plan and that he or she has reviewed the notice and certification and understands the consequences of declining coverage under the Benefit Plan. Group agrees to submit all completed notices and certifications to Plan for:

a. Each Eligible Participant and/or his or her Dependents who declined coverage at renewal of this Group Agreement; and,
b. Each Eligible Participant and/or his or her Dependents who became eligible during the term of this Group Agreement specified on the Cover Page and who have declined coverage.

IV. ADMINISTRATION

A. Group shall provide Plan with a list of Members at least 5 business days prior to the date coverage hereunder commences.

B. The Plan shall issue identification cards or other data identifying each Member as being eligible for services under the Benefit Plan.

C. Plan shall be responsible for the preparation of materials, such as the Evidence of Coverage Booklet, Schedule of Benefits, and other material required to be distributed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Knox-Keene Act"), and any regulations issued thereunder. Plan shall provide Group with sufficient numbers of said materials for distribution by Group to its Subscribers.

D. Except as may otherwise be specifically required under this Group Agreement, the Evidence of Coverage Booklet, or applicable law, whenever the Plan is obligated to give any notice to Members of Group with regard to any matters covered by this Group Agreement, or the Knox-Keene Act or any regulations issued thereunder, it shall be sufficient for the Plan to give such notice to Group. Group shall then give that notice to its Members no later than 30 days after the Plan gives such notice to Group. Upon request, Group shall provide Plan with copies of its notices given to Members under this Section IV.D.

E. Should any Participating Provider be unable to continue in such capacity, whether for breach of contract, inability to perform, or termination by the Plan, and the inability of the Participating Provider to perform may materially and adversely affect the Group, the Plan shall notify Group of the Participating Provider's inability in writing within a reasonable time.

V. DURATION OF AGREEMENT, CHANGES, RENEWAL AND TERMINATION:

A. Effective Date; Term; Renewal; Modification of Terms on Renewal. This Group Agreement shall be effective on the date indicated on the Cover Page and shall continue for the initial term specified on the Cover Page. Unless the Group terminates this Group Agreement by giving the Plan written notice no less than sixty (60) days prior to the end date of the initial term or any subsequent renewal term, this Group Agreement shall automatically renew for a subsequent renewal term as specified on the Cover Page. The Plan may change Prepayment Fees and Benefits and Coverage effective upon commencement of a renewal term of the Group Agreement by giving notice setting out the changes at least sixty (60) days prior to the commencement of the term for which the changes are to be effective.

B. Offer of Conversion Coverage Following Termination. The Plan may affirmatively market and offer conversion privileges as set forth in the Evidence of Coverage Booklet to Members who become ineligible due to the termination of the Group Agreement.

C. Modification of Benefits and Coverage and Prepayment Fees During Term. The Plan may change the Prepayment Fees or the Benefits and Coverage under this Group Agreement at any time during the initial and renewal terms of the Group Agreement by giving written notice setting out the change or changes at least 60 days prior to the effective date of the change. **[Note: The following sentence was deleted because it is not a regulatory requirement.]** . The Group may reject such changes and terminate this Agreement within such 60 day period by giving notice to the Plan as set forth in Section VIII.B., and the effective date of any such termination shall be the last day of the month following the expiration of 60 days after the Group rejects the Plan's changes and gives notice of such to the Plan. Payment of any portion of the increased Prepayment Fees shall constitute acceptance of this modification. The provisions of this Section V.C. shall not apply to any modifications to be effective upon the commencement of any renewal term of the Group Agreement.

D. Amendments. In addition to amendments pursuant to Section V.C. above, the Parties may by mutual consent modify or amend this Group Agreement. However amendments under this Section V.D. shall be in writing, duly executed by both Parties and attached to the Group Agreement.

E. Termination or Non-Renewal. The Plan may terminate this Group Agreement, or decline to renew it in any of the following circumstances:

1. Failure to Pay Prepayment Fees. Group fails to pay any Prepayment Fee when due under this Group Agreement. Plan shall provide notice of termination stating that all unpaid Prepayment Fees must be received by the Plan within thirty (30) days of the notice date, and that if payment is not received within the thirty (30) day period, coverage for all Members will be cancelled as of the first day after expiration of the notice period.

   a. Reinstatement. Receipt by the Plan of the proper Prepayment Fee after termination of this Group Agreement for nonpayment shall reinstate this Group Agreement as though it had never been cancelled, if such payment is received on or before the due date of the succeeding Prepayment Fee. However, the Plan may avoid such reinstatement by one or more of the following methods:

      i) Specifying in the notice of termination, that if payment is not received within 30 days of issuance of such notice, a new application will be required and the conditions under which a new contract will be issued or the original agreement reinstated; or

      ii) If such payment is received more than 30 days after issuance of the notice of termination, the Plan refunds such payment within 20 business days; or

      iii) If such payment is received more than 30 days after issuance of the notice of termination, the Plan issues to Group within 20 business days of receipt of such payment, a new contract accompanied by written notice stating clearly those aspects in which the new contract differs from the terminated contract in benefits, coverages and other aspects.

2. Fraud or Deception in Use of Services. Group engaged in fraud or deception in the use of the services or facilities of the Plan or knowingly permitted such fraud or deception by someone else. Termination shall be effective on the date specified in written notice of termination given by the Plan, and no less than 30 days after such notice.

3. Fraud or Deception with Respect to Coverage. Group engaged in fraud or misrepresentation with respect to this Group Agreement or the coverage of any person. Termination shall be effective on the date specified in written notice of termination given by the Plan, and no less than 30 days after such notice.

4. Failure to Comply with Contribution Requirements. Group failed to comply with the applicable Group contribution level requirements set forth in the Cover Page. Termination shall be effective on the date specified in written notice of termination given by the Plan, and no less than 30 days after such notice.

F. Plan Notice of Termination; Group Notice of Termination to Members; Provision to Plan of Proof of Notice. If the Plan terminates the Group Agreement pursuant to Section V.E., the Plan shall notify the Group in writing of the termination of this Group Agreement. The Group shall then mail promptly to each Member a legible, true copy of any notice of termination of this Group Agreement received from the Plan and shall provide promptly to the Plan a certification signed by a representative from the Group that notice was mailed to each Member and the date such notice was mailed.. The notice of termination to Members shall include information in clear and easily understood language regarding the individual continuation of benefits and conversion rights available to Members, as described in the Evidence of Coverage Booklet. If the Group fails to provide the Plan with proof of mailing within two (2) weeks from the date of the notice of termination, the Plan will promptly mail each Member a copy of the notice of termination. When the Group Agreement is terminated pursuant to Section V.E.4., the notice to Members will include additional notice that the effective date of the termination shall be no earlier than 15 days after the notice is mailed to the Member.

G. Refund of Premium. The Plan shall, within 30 days of termination of this Group Agreement, refund the prorated portions of the Prepayment Fees which correspond to an unexpired term for which payment has been received, less any amounts due the Plan. The Group shall remain liable to Plan for Prepayment Fees due through the date of termination.

VI. PREPAYMENT FEES, COMMENCEMENT OF COVERAGE

A. Group hereby agrees to pay to the Plan the monthly Prepayment Fees set out in the Cover Page for the duration of this Group Agreement commencing on the date as stated in the Cover Page.

B. Prepayment Fees must be paid in full on or before the 25th **[Note: this due date may change in view of the change in invoicing procedures]** day of the same month to which the Prepayment Fee applies. (For example, Prepayment Fees for the month of July are due no later than July ____.) Group shall pay Prepayment Fees at the Plan's principal place of business as indicated in Section VIII.B. herein.

C. Group shall provide a monthly eligibility list with the names and other identifying data of all Members to be covered in the succeeding month. Said list shall be provided to the Plan no later than the 25th of the month prior to the

month in which coverage is effective, and shall specifically identify the following:

1. All new Members.
2. All Member deletions.
3. All current Members covered.

If Group fails to give adequate and timely notice to the Plan of a Member’s loss of eligibility or provides the Plan with inaccurate information regarding a Member's eligibility, then, Group shall promptly pay the Prepayment Fees for such non-eligible Member or reimburse the Plan for its expenses incurred in providing covered benefits to such non-eligible Member, whichever is higher.

Group shall be responsible for reviewing monthly invoices submitted by the Plan and shall be responsible for payment of all charges on the invoice unless disputed charges are reported to Plan prior to the issuance of the succeeding monthly invoice.

D. Coverage shall commence on the date set out in the Cover Page for all Members enrolled when the Benefit Plan begins, and, for subsequently enrolled Members, on the first day of the month following the date of enrollment.

VII. NOTICE REGARDING CONTINUATION COVERAGE

Upon the occurrence of a qualifying event, as defined in the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended by the 1986 Tax Reform Act (P.L. 99-514) and the 1986 (Omnibus Budget Reconciliation Act (P.L. 99-509) (“COBRA”), Group shall provide affected Members with written notice of available continuation coverage as required by and in accordance with COBRA and amendments thereto. Group shall be solely responsible for collecting premiums from Members who elect COBRA continuation coverage and shall transmit those premiums to Plan simultaneously with monthly periodic fees for Member coverage due under this Group Agreement. Group shall maintain accurate records regarding COBRA Members as necessary to administer COBRA continuation of benefits. Group remains liable to Plan for any failure of a third party retained by Group to fulfill the obligations of this Article VII.

VIII. GENERAL PROVISIONS

A. The waiver by either of the Parties of one or more defaults, if any, under this Group Agreement shall not be construed to operate as a waiver of any other or future default, either in the same condition or covenant or any other condition or covenant contained in this Group Agreement.

B. Whenever it shall become necessary for either Party to serve notice on the other respecting this Group Agreement, such notice shall be in writing and

shall be served by certified mail, return receipt requested. If addressed to the Plan, such notice shall be addressed as follows:

WESTERN DENTAL SERVICES, INC.
530 South Main Street, 6th Floor
Orange, California 92868

Plan telephone number: 1-800-992-3366

If addressed to Group, such notice shall be addressed as stated on the Cover Page.

C. Throughout this Group Agreement the singular shall include the plural and the plural shall include the singular; the masculine shall include the feminine and the neuter, and the feminine and the neuter shall include the masculine.

D. If any provision of this Group Agreement is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Group Agreement, and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevents the accomplishments of the objectives and purposes of this Group Agreement.

E. The Plan is subject to Chapter 2.2 of Division 2 of the Health & Safety Code of the State of California (the "Knox-Keene Act") and to regulations issued thereunder by the Department of Managed Health Care (Title 28 of the California Code of Regulations). Should either the Knox-Keene Act or the regulations be amended, such amendments shall automatically bind the Plan, whether or not they are actually included in this Group Agreement.

F. Any provision required to be in this Group Agreement by either law or regulation shall automatically bind the Plan, whether or not such provision is actually included in this Group Agreement.

G. Group covenants and hereby agrees that it will not sell, assign or transfer this Group Agreement without the specific prior written consent of the Plan, and such sale, assignment or transfer shall be null and void and shall act as a default of this Group Agreement. The consent of the Plan to any one sale, assignment or transfer shall not waive the Plan's right with respect to declining to consent to any other sale, assignment or transfer. Plan may sell, assign or transfer its rights and delegate its duties hereunder to any entity which is a licensed health care service plan into which it is merged or which acquires substantially all of its assets, upon the approval of the Department of Managed Health Care.

H. This Group Agreement constitutes the entire agreement of the Parties. There are no oral representations or agreements not embodied in this written Employer Agreement. Except as provided in Sections V.A and V.C., this

Group Agreement may only be modified by a writing executed by both parties pursuant to Section V.D.

I. Each of the Parties hereby acknowledge that it has read this Group Agreement, understands its contents and executes it voluntarily.

J. Group hereby represents that it has the authority under applicable law to execute this Group Agreement and has passed all necessary resolutions giving it authority to do so.

K. Discrimination Prohibited

1. The Plan shall not refuse to enter any contract or shall not cancel or decline to renew or reinstate any contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, or any physical or mental impairment of any contracting party, or person reasonably expected to benefit from any such contract as a Member or otherwise.
2. The terms of any contract shall not be modified and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reduction, co-payments, co-insurance, deductibles, reservations, or premium, price or charge differentials, or other modifications because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, or any physical or mental impairment of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a Member or otherwise; except that premium, price or charge differentials because of the sex or age of any such individual and based on objective, valid and up-to-date statistical and actuarial data are not prohibited.

L. This Group Agreement does not provide any exception for other coverage where the other coverage is entitlement to: (i) Medi-Cal benefits under Chapter 7 or Chapter 8 of Part 3 of Division 9 of the California Welfare and Institutions Code; or (ii) Medicaid benefits under Subchapter XIX (beginning with Section 1296) of Chapter 7 of Title 42 of the United States Code. This Group Agreement also does not provide an exemption for enrollment because a Member is entitled to Medi-Cal or Medicaid benefits.

M. It is agreed that this Group Agreement, together with the Cover Page, Evidence of Coverage Booklet, Schedule of Benefits, and any amendments shall, when accepted by Plan, constitute the entire agreement of the Parties.

N. Neither Group nor its employees or agents are the employees or agents of the Plan, and neither the Plan nor its employees or agents are the employees or agents of Group. The Parties shall not be liable for any acts or admissions of the other, their agents or employees.

O. Except as otherwise expressly indicated in this Group Agreement, this Group Agreement shall not create any rights in any third parties who have not entered into this Group Agreement, nor shall this Group Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

P. Plan reserves the right to control all of its names, product names, symbols, logos, trademarks, and service marks currently existing or later established. Group shall not use the Plan's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of the Plan.

Q. Headings. The headings of the various Sections of this Group Agreement are inserted merely for the purpose of convenience and do not expressly, or by implication, limit or define or extend the specific terms of the Section so designated.

R. Regulatory Disclosures.

1. The Plan shall annually disclose to the governing board of a public agency that is the subscriber of this group contract, the name and address of, and amount paid to, any agent, broker, or individual to whom the plan paid fees or commissions related to the public agency's group contract. As part of this disclosure, Plan shall include the name, address, and amounts paid to the specific agents, brokers, or individuals involved in transactions with the public agency. The compensation disclosure required by this section is in addition to any other compensation disclosure requirements that exist under law.

2. All family plans shall receive immediate coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the subscriber's or spouse's right to control the health care of the child placed for adoption.

3. All family plans shall terminate upon attainment of the limiting age for dependent children specified in the plan, but that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

(A) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.

(B) Chiefly dependent upon the subscriber for support and maintenance.

The Dependant child's coverage will terminate upon attainment of the limiting age unless the subscriber submits proof of the criteria described in subparagraphs (A) and (B) of paragraph (1) to the plan within 60 days of the date of receipt of the notification. The plan shall send this notification to the subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described in subparagraphs (A) and (B) of paragraph (1), the plan shall determine whether the child meets that criteria before the child attains the limiting age. If the plan fails to make the determination by that date, it shall continue coverage of the child pending its determination. The plan may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under this subdivision but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

4. The terms and conditions under which Subscribers and Members may remain in the Plan in the event the Group ceases to exist, this Group Agreement is terminated or an individual subscriber leaves the Group, or the enrollees' eligibility status changes are as follows: Membership for which Prepayment Fees have been paid shall continue until the original term expires.

IX. ARBITRATION

A. The attached Evidence of Coverage Booklet includes a complete description of the appeals and grievance procedures and dispute resolution processes for Members.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at 1-800-992-3366 and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service

or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

B. All disputes between Group and Plan shall be resolved by binding arbitration before JAMS, a non-judicial arbitration and mediation service. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time a demand for arbitration is made will be applied to the arbitration. The Parties will seek to mutually agree on the appointment of an arbitrator; however, if an agreement cannot be reached within 30 days following the date demanding arbitration, the Parties will use the arbitrator appointment procedures in the Rules. Arbitration hearings will be held at the neutral administrator's offices in Orange County, California or at another location agreed upon in writing by the Parties. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected will have the power to control the timing, scope and manner of the taking of discovery and will have the same powers to enforce the Parties' respective duties concerning discovery as would a Superior Court of California. This includes, but is not limited to, the imposition of sanctions. The arbitrator(s) will have the power to grant all remedies provided by California law. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. The Parties will divide equally the fees and expenses of the arbitrator(s) and the neutral administrator. The arbitration decision is final and binding on the Parties, and the award may only be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-4, will also apply to the arbitration.

C. <u>Mandatory Arbitration</u>: Group, Member and Plan agree and understand that any and all disputes, including claims of dental malpractice, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Each party to this agreement is giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

Executed at _____, ______________ California, this ____ day of ________, 20____.	Executed at Orange, California, this ____ day of ________, 20___.
______________________________ ORGANIZATION (NAME)	WESTERN DENTAL SERVICES, INC.
By____________________________ Signature of Officer, Partner, Proprietor	By____________________________ Western Dental Authorized Signature
______________________________ Name	____________________________________ Name