WASHINGTON PARISH SCHOOL BOARD

ALWAYSCARE DENTAL

IN NETWORK BENEFITS ONLY PLAN

By signing below, I acknowledge that I have been made aware of the AlwaysCare Dental In-Network Benefits Only Plan participation requirements.

The AlwaysCare Dental In-Network Benefits Only Plan will not pay any benefits for a provider that is not in the network (must see a participating provider).

I am aware that participating providers may change and it is my responsibility to be sure the dentist I choose is a participating provider.

Print Name: _____ Date: _____

Signature_____

Location: _____