- **Are you working with no dental benefits?**
- **Are you retired with no dental benefits?**
- **Are you a recent graduate with no dental benefits?**

Then

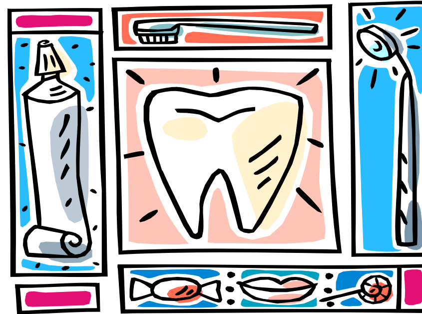
Michigan Community Dental Plan

might be for you!

Michigan Community Dental Plan offers dental services at a reduced fee for people without dental insurance. If you are eligible, your membership includes an initial visit with a participating dentists that will include x-rays, an exam, a treatment plan and reduced rates for all treatment.

Membership is $50.00 per person.

To be eligible for the program, you must have no other dental insurance.



To participate in the program, fill out the application on the back of this brochure and mail it to MCDC. Applications are available at all MCDC offices, participating health departments and participating dentists' offices.

Once your application and membership fee have been received and processed, your membership card will be mailed to you along with a list of participating private dentists in your area. Then, call any MCDC office or any participating dentist to make an appointment.

For more information visit

www.midental.org

or call the nearest MCDC office

Alpena
866.878.6547

Big Rapids
866.796.3677

Cadillac
866.878.6549

Cheboygan
866.878.6550

East Jordan
866.878.6551

Gaylord
866.878.6552

Harbor Springs
866.878.6556

Hart
231.873.9340

Mancelona
866.878.6553

Manistee
866.878.6554

Marquette
906.226.9992

Port Huron
810.984.5197

Traverse City
866.878.6557

Three Rivers
877.283.8889

West Branch
866.878.6558

Mt. Pleasant
989-772-4026

Sidney
877-328-0777

Complete the following information for each person requesting membership:

Last Name	First name	Birth Date	Membership Fee
1. ______	______	______	______
2. ______	______	______	______
3. ______	______	______	______

Address: ____________________ *City:* ____________ *Zip*__________

Phone Number : ____________________ *Location of desired clinic:*____________________

Please include payment: __________*Check or Money Order payable to MCDC, Inc.*

__________ *VISA or MasterCard: Account Number* ____________________ *Exp.*__________

*Signature*____________________*CIS#*__________

Your application cannot be processed without your payment. Please mail this application with payment to:

Michigan Community Dental Clinics, Inc.
218 W. Garfield Street
Charlevoix, MI 49720

Michigan Community Dental Plan

www.midental.org