



## Provider Credentialing Application Checklist

Please complete and return this document to ensure efficient processing of your application.

### What networks are you interested in joining?

- Dental Guard PPO** (available in all states)
  - Dental Guard Alliance** (available in some states. Participation in Dental Guard PPO required.)
- Guardian DHMO** (available in CA, CO, CT, FL, IL, IN, MI, MO, NJ, NY, OH, TX)

### Be sure that:

- Each dentist** has completed the Provider Credentialing Application
- All sections** of the form are filled out completely
- Your SSN, Date of Birth and NPI** are included (even if you submit claims under a different number)
- The Tax ID Number you use to submit claims** is included for each location
- Thorough explanations** are given for any YES answers to Questions 1-14
- Your Signature and Date** appear on the Attestation (p. 5) *Note: Signatures expire after 180 days*

### Include copies of the following documents:

- Current DEA Certificate** (or DEA waiver) and **CDS Certificate** as applicable
- Current state(s) dental license(s)**
- Specialty Certificate** as applicable
- Professional Liability Insurance Declaration Page** (not general insurance)
- Signed and Dated Agreement** – please list of all locations that should be considered in-network
- W-9** (2018 version or later)

### For DHMO please also include:

- Associate Acknowledgement Form** (General Dentist only)
- Economic Profile Form** (California only)

To ensure timely processing, please send information directly to our Network Services Department.

You may email provider applications to [PPO RC Dental@glic.com](mailto:PPO_RC_Dental@glic.com)

You may also fax to **509-464-8019**

You may also mail to **DentalGuard Networks, P.O. Box 981574, El Paso, TX 79998**

If you have questions, please call **866-229-1970**



## Provider Credentialing Application

### General Information

Full Name: \_\_\_\_\_  
First      Middle      Last      Suffix      Degree  
Provider Email: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Gender:  Female  Male  Non-Binary      Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birth Date: \_\_\_\_\_ NPI-1: \_\_\_\_\_

**Home address:** Please complete in full.

Street address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please include any other name(s) for which you have been known:**

Full Name(s): \_\_\_\_\_ From \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_  
(MM/YYYY)      (MM/YYYY)

**Dental License:** Please provide current and expired dental license details with issue and expiration dates in MM/DD/YYYY format.

Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**DEA Certification(s):** Please provide DEA certification details with issue and expiration dates in MM/DD/YYYY format.

DEA Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DEA Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Controlled Substance Certificate:** Please provide details of CSC registrations.

Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Anesthesia Permit:** Please provide details of Anesthesia Permits.

Number: \_\_\_\_\_ Status: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Additional or Other Certification(s):** Please provide details of any other certifications.

Certificate Type: \_\_\_\_\_ Certificate number: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Certificate Type: \_\_\_\_\_ Certificate number: \_\_\_\_\_  
State: \_\_\_\_\_ Issue Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Primary Service Location:** Please provide full details for your primary location. If practicing at multiple locations, please list any additional locations on a separate page.

Practice Type:  Family Planning  FQHC  Indian Health Clinic  Mobile  Ryan White  Teledentistry

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_

Credentialing Phone: \_\_\_\_\_ Credentialing Email: \_\_\_\_\_

Group NPI-2: \_\_\_\_\_ Are Credit Cards Accepted?  Yes  No

**Emergency & Patient Access Services:** Please provide practice capabilities.

Age of patients accepted From \_\_\_\_\_ To \_\_\_\_\_ Are emergency services available 24 hours per day?  Yes  No

Method of Access:  Answering Service  Urgent Care  Emergency Room  Emergency Phone# \_\_\_\_\_

Accepts patients with disabilities  Yes  No Teletype available  Yes  No

ADA compliant accessible office  Yes  No Accessible parking  Yes  No

CPR certified staff  Yes  No Accepts new patients  Yes  No

Endodontics:  Anterior root canal treatment  Bicuspid root canal treatment  Molar root canal treatment

Periodontics:  Surgical periodontal services

Oral Surgery:  Erupted tooth surgical removal  Impaction tooth removal

Restorative:  Amalgam restorations  Scaling and root planing  Composite restorations

Pediatric Dentistry:  Routine care <8 years old  Routine care > 8 years old

**Please indicate which services are offered at this location:**

Nitrous Oxide  General Anesthesia  IV sedation  Oral sedation  Panoramic X-ray  Intraoral X-ray

Electronic Claim Submission  Digital radiograph submission

**Sterilization method:**  Autoclave  Chemclave  Other

**Please indicate all languages spoken at this location.**

English  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

**Please provide the hours of operation at this location:**

Monday \_\_\_\_\_ to \_\_\_\_\_  Tuesday \_\_\_\_\_ to \_\_\_\_\_  Wednesday \_\_\_\_\_ to \_\_\_\_\_

Thursday \_\_\_\_\_ to \_\_\_\_\_  Friday \_\_\_\_\_ to \_\_\_\_\_  Saturday \_\_\_\_\_ to \_\_\_\_\_

Sunday \_\_\_\_\_ to \_\_\_\_\_



Provider Full Name: \_\_\_\_\_ NPI-1: \_\_\_\_\_

**Correspondence Address:** Please indicate the address to which you would like all written correspondence sent.

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Office Manager's email address: \_\_\_\_\_

**Billing Address:** Please indicate the address to which you would like all payment remittances sent.

Same as correspondence address

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Manager's email address: \_\_\_\_\_

**Provider Specialty:** Please indicate specialty, if other than General Dentist.

Primary specialty: \_\_\_\_\_

**Board Certification:** Please complete all applicable fields.  Not Applicable

Name of Board: \_\_\_\_\_

Board Status: \_\_\_\_\_ Lifetime Certified:  Yes  No

Certification Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Education:** Please complete all relevant fields.

Education Type:  Undergraduate  Graduate  Post graduate Degree Earned: \_\_\_\_\_

Institution Name: \_\_\_\_\_ From \_\_\_\_\_ / \_\_\_\_\_ To \_\_\_\_\_ / \_\_\_\_\_  
(MM/YYYY) (MM/YYYY)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country (if non-US) \_\_\_\_\_

Education Type:  Undergraduate  Graduate  Post graduate Degree Earned: \_\_\_\_\_

Institution Name: \_\_\_\_\_ From \_\_\_\_\_ / \_\_\_\_\_ To \_\_\_\_\_ / \_\_\_\_\_  
(MM/YYYY) (MM/YYYY)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country (if non-US) \_\_\_\_\_

## Work History

**Beginning with the most current and in chronological order, please list all places of clinical practice and/or employment over the last 5 years since completion of training. In addition, please explain any gaps greater than 6 months or more on a separate piece of paper unless otherwise mandated by your state. If currently employed, please leave 'to' date blank and check box instead.**

Employer: \_\_\_\_\_ Date (MM/YYYY) From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ Currently Employed:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Date (MM/YYYY) From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ Currently Employed:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Date (MM/YYYY) From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ Currently Employed:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Date (MM/YYYY) From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ Currently Employed:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Date (MM/YYYY) From \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ Currently Employed:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Work Gap Explanation(s):

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## Attestation Questions

Please answer each of the following questions. Any questions answered adversely will require a detailed explanation.

1. Have any of the following ever been or are currently under investigation or restriction? (e.g., denied, revoked, suspended, probated, not renewed)?
  - a. License to practice in any jurisdiction  Yes  No
  - b. Board certification  Yes  No
  - c. Federal DEA Registration  Yes  No
  - d. State Controlled Substance Registration  Yes  No
  - e. Clinical Privileges  Yes  No
  - f. Participation in the Medical/Medicaid programs  Yes  No
  - g. Membership in other hospital/healthcare facility medical/ professional staff  Yes  No
  - h. Professional society membership  Yes  No
2. Have you ever been convicted of, or have any charges pending against you, related to a felony or misdemeanor, other than minor traffic offenses?  Yes  No
3. Has any professional liability coverage ever been denied, cancelled, reduced, limited, terminated, or not renewed due to action taken by an insurance carrier?  Yes  No
4. Are you requesting any privileges not covered by your professional liability insurance?  Yes  No
5. Have any professional liability suits filed resulted in a judgement against you or been terminated pursuant to a settlement in which you have paid damages to a plaintiff, with or without admitting liability?  Yes  No
6. Have you ever settled any professional liability claim against you prior to a suit and admitted liability as part of such a settlement?  Yes  No
7. Are you now or have you ever engaged in the illegal use of controlled substances?  Yes  No
8. Are you currently or have you ever participated in a supervised rehabilitation program or professional assistance program as a patient?  Yes  No
9. Within the last 10 years, has a suit been filed against an institution or entity based on alleged negligent medical acts or omissions by you (even if dismissed or dropped) other than identified above (e.g., a suite against a teaching hospital, university, governmental entity or other employers)?  Yes  No
10. In the last 10 years, has a settlement been made by an institution based upon alleged negligent medical acts or omissions by you?  Yes  No
11. Are you currently, or have you ever been, the subject of an individual focused review by a healthcare facility's Quality Assurance, Utilization Review, Risk Management, Peer Review or similar monitoring committee?  Yes  No
12. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to a patient?  Yes  No
13. Do you have a condition that could compromise your ability to perform any of the mental and physical functions related to the specific clinical privileges you are requesting?  Yes  No
14. Within the last 5 years, have you had any gaps of 6 months or greater, where you did not work as a practitioner in this current discipline? If "Yes", please explain the reason(s) for any gap(s) on a separate sheet.  Yes  No



Provider Full Name: \_\_\_\_\_ NPI-1: \_\_\_\_\_

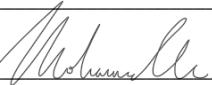
### Attestation & Credentials Release of Verification

I attest that all information provided in this Application is true and complete to the best of my knowledge and belief. I will notify The Guardian Life Insurance Company of America and/or its affiliates as well as their agents ("Guardian"), through designated contact person/method, within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of membership and/or privileges or affiliation by Guardian, and must be submitted on-line or in writing, and must be dated and signed by me.

I, the undersigned Provider, authorize Guardian, to whom information on this Application may be released on an ongoing and continuing basis, as well as anyone with whom it may enter into a contract with (collectively, "Representatives") to obtain information from others, including but not limited to: state licensing authorities, certification boards, National Practitioner Data Bank (NPDB), professional liability and malpractice insurance carriers (including claim histories and loss reports), hospitals, substance abuse programs, members of medical or other professional staffs, dental administrators, hospital administrators and health-care-related employers that may be necessary to evaluate my qualifications, including without limitation, my professional competence and conduct, information about disciplinary actions and information that might otherwise be considered confidential or privileged (collectively, "Credentialing Information"). I authorize Guardian to request and receive verification of Credential Information and authorize Guardian to monitor my credentials on an ongoing and continuing basis. I understand that I have the burden of providing adequate and accurate information to demonstrate my qualifications and that statements written on this application will be considered statements made by me, even if prepared by another, including but not limited to an employee, agent or representative.

I attest that the information contained in this application is correct and complete and understand that any misstatement or omission on this application may constitute grounds for rejection of my application or dismissal as Participating Provider with Guardian's or its client-sponsored networks. I understand that it is my ongoing obligation to immediately notify Guardian: (i) of any changes to the information provided (including but not limited to changes to professional liability insurance, malpractice status, physical or mental condition, or state dental license status), or (ii) if I have reason to believe or become aware that any information provided is inaccurate or inadequate. I understand that if Guardian denies my application or otherwise takes action that is adverse to my request for participation, Guardian may be obligated, under applicable law, to report such action to the NPDB and/or other licensing or accreditation agencies. I authorize Guardian to disclose any and all Credentialing Information to its members, payor clients or other entities who may lease a Provider Network from Guardian, subject to applicable law, rules and regulations. I understand that credentialing requirements may vary from state to state and additional information may be required. I release Guardian from any and all liability for acts performed in good faith and without malice in obtaining and verifying the information collected and evaluating my application. I agree that a digital image of this document, as executed, shall be considered as a true and correct original and admissible as best evidence to the extent permitted by a court with proper jurisdiction.

**Print Provider's Name:** \_\_\_\_\_

**Provider's Original Signature:** 

*Note: Stamped signatures will not be accepted*

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**DentalGuard Networks**  
P.O. Box 981574  
El Paso, TX 79998-1574  
1-800-890-4774

## Participating Dentist Agreement

This Participating Dentist Agreement (the "Agreement") by and between \_\_\_\_\_ ("Dentist") and The Guardian Life Insurance Company of America, a mutual life insurance company organized under the laws of the State of New York ("Guardian").

**WHEREAS**, Guardian has entered into agreements with dental care professionals ("Participating Dentists") to provide professional dental services through individual and group contracts and network rental or leasing arrangements ("Plans") with individuals, employee groups, unions, corporations, insurance companies, third party administrators, third party entities seeking access to dental services through network rental or leasing and other payors (collectively, "Clients") and to make such dental services available to eligible individuals, employees or members of such Clients and their covered dependents ("Covered Individuals"); and

**WHEREAS**, Dentist is willing to act as a participating dental care professional and provide dental services to Covered Individuals of such Plans under the terms and conditions set forth below.

**NOW, THEREFORE**, in consideration of the promises and mutual covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually covenanted and agreed as follows:

### I. **OBLIGATIONS AND RESPONSIBILITIES OF DENTIST**

#### 1.1 Dentist's obligations and responsibilities include, but are not limited to, the following:

(i) **Provision of Dental Services.** Dentist agrees to provide Dental Services (as defined below) to Covered Individuals eligible for benefits in DentalGuard Preferred Network Plans, DentalGuard Preferred Select Network Plans and such other Plans as are set forth on each page of the Chosen Networks Addendum to this Agreement that is attached hereto and executed by the Dentist ("Chosen Networks"). Dentist's provision of Dental Services shall be subject to and in compliance with the terms and conditions of this Agreement (including any schedules, addenda and exhibits), applicable policies, procedures, and the Network Operations Manual applicable to the Chosen Networks in each applicable state (collectively, the "Dentist Manuals"), the terms of which are hereby incorporated by reference (applicable policies and procedures together with the Dental Manuals shall hereinafter be referenced as the "Policies and Procedures"). A copy of the applicable Dentist Manual(s) shall be made available to Dentist upon request. Dentist should review the applicable Dentist Manual(s) prior to signing this Agreement. This Agreement may further apply to network rental or leasing arrangements and may be used for the purpose of allowing a third party, through an agreement with Guardian, access to Dentist's services at the applicable Fee Schedule. Dentist shall ensure that all services provided to Covered Individuals are consistent with professionally recognized standards of practice and applicable law.

For the purpose of this Agreement, the term "Listed Service" shall mean, for each Chosen Network, the services listed on the schedule(s) of fees that Guardian shall provide to each Dentist for such Chosen Network (each a "Fee Schedule" and, collectively, "Fee Schedules"). The Fee Schedules for the Chosen Networks shall be attached to this Agreement as sequentially numbered exhibits, i.e., Exhibit A, Exhibit A-1, Exhibit A-2, etc. Dentist and Guardian agree that if no separate Fee Schedule for the DentalGuard Preferred Select Network is attached to this Agreement, the Fee Schedule for the DentalGuard Preferred Network shall apply to Dental Services provided to Covered Individuals eligible for benefits in DentalGuard Preferred Select Network Plans. The Fee Schedules may be amended or supplemented from time to time as provided for herein.

For purposes of this Agreement, the term "Covered Services" shall mean those services, including procedures, supplies and appliances, which are covered under a Plan, subject to the provisions and limitations of such Plan. Listed Services and Covered Services shall be referenced herein together as "Dental Services".

(ii) **Non-discrimination.** Dentist agrees not to differentiate or discriminate in the delivery of services to Covered Individuals on the basis of race, sex, sexual orientation, age, religion, place of residence, or health status; and to observe, protect and promote the rights of Covered Individuals as patients.

(iii) **Dentist Manuals.** Dentist agrees to participate in and abide by all terms and conditions contained in the Dentist Manuals applicable to the Chosen Networks, including, without limitation, Guardian's complaint procedures, peer review, credentialing, utilization review ("UR") program, utilization management ("UM") program, and quality management ("QM") program.

(iv) **Notification Requirements.** Dentist agrees to notify Guardian pursuant to Section 5.1 of this Agreement within two (2) business days of any of the following: (a) the restriction, limitation, conditional status, probation, suspension, revocation or voluntary relinquishment of his/her license to practice dentistry in any state or the commencement of any investigation or action which could result in such restriction, limitation, conditional status, probation, suspension or revocation or the commencement of any action by the board of dentistry of any state regarding such licensure; (b) the loss or restriction of his/her DEA permit (as applicable); (c) the voluntary or involuntary relinquishment of his/her participation in any governmental program or the restriction, limitation, conditional status, probation, suspension or revocation or the commencement of any investigation or action which could or does result in a restriction, limitation, conditional status, probation, suspension or revocation of his/her participation in any governmental program; (d) the commencement of or receipt of written notice of the intention to commence an action which could reasonably result in any legal action against Dentist for negligence, malpractice or professional misconduct and the final disposition of the action; (e) any indictment, arrest or conviction for a felony whether or not related to dentistry or for any criminal charge related to the practice of dentistry; (f) any lapse or material change in any insurance coverage required by this Agreement; (g) any representation or warranty made by Dentist herein becoming untrue; (h) receipt of any notice relating to a complaint of a Covered Individual; or (i) the occurrence of any other event which would likely have an adverse effect on the ability of the Dentist to provide Dental Services hereunder.

1.2 **Representations and Warranties.** Dentist hereby represents, covenants and warrants that (i) all statements made in his/her application to become a Dentist or otherwise made to Guardian in connection with this Agreement are, and shall remain during the term of this Agreement, true and complete; (ii) he/she holds a valid and currently unrestricted, unconditional and unlimited dental license from or is recognized by, the licensing authorities of each state in which he/she practices as holding a valid dental license, or he/she holds a valid medical license which allows for the practice of dentistry in sufficient scope to provide Dental Services hereunder; (iii) he/she holds an unrestricted Drug Enforcement Administration ("DEA") permit (as applicable); and (iv) he/she performs services in the office(s) indicated on the signature page of this Agreement.

## **II. ADDITIONAL CONDITIONS AND PROVISIONS**

Dentist agrees to abide by the following:

**2.1      Independent Contractor.** The relationship of Dentist to Guardian or any affiliate of Guardian is not that of an employee.

None of the provisions of this Agreement are intended to create, nor shall they be construed to create, an agency, partnership, joint venture, or employee-employer relationship between Dentist and Guardian or an affiliate of Guardian. Dentist will not be treated as an employee of Guardian for any reason, including, but not limited to, the Federal Unemployment Tax Act, the Workers' Compensation Act, Federal Insurance Contributions Act, and income tax withholding at the source. In this capacity, Dentist shall have sole responsibility for the payment for all employment and Federal, State and local income taxes.

**2.2      No Subcontracting.** Dentist shall not subcontract or otherwise delegate any of his/her duties under this Agreement without the express written consent of Guardian. Dentist shall require any entity to which it subcontracts or delegates any of its duties under this Agreement to strictly comply with the terms of this Agreement to the same extent as Dentist. Notwithstanding the foregoing, Dentist shall remain directly responsible to Guardian for all of his/her obligations set forth herein, regardless of whether Dentist subcontracts or delegates such duties to a third party.

**2.3      UR/UM/QM Programs.** Dentist agrees to cooperate with Guardian's UR, UM and QM programs and to abide and be bound by all UR, UM and QM decisions made by Guardian or any agent or representative of Guardian.

**2.4      Dental Records.** Dentist shall maintain or cause to be maintained, at such place where services are rendered to Covered Individuals, adequate dental records relating to the provision of such services which records shall be retained for the time required under applicable law.

Dentist agrees to promptly provide copies of all dental records (by mail, email or fax) as requested by Guardian to facilitate Guardian's review of a Covered Individual's claim or complaint. Dentist agrees that all Covered Individuals' dental records shall be treated as confidential so as to comply with all state and federal laws regarding confidentiality of patient records; however, subject to applicable law, both Guardian and any state's Department of Insurance shall have the right to inspect, at the place where such records are kept, with or without notice, any dental records and financial and administrative records maintained by Dentist which pertain to Covered Individuals.

**2.5      Liability Insurance.** Dentist shall at his/her sole expense, throughout the term of this Agreement, maintain a policy of professional liability insurance, including tail coverage as applicable in an amount not less than the greater of: (i) an amount sufficient to cover their anticipated risk; (ii) the amounts required by the applicable law or regulation, or (iii) for dentists designated (or requesting to be designated) by Guardian as (x) a general dentist: two hundred thousand dollars (\$200,000.00) for injury or death of any one person and five hundred thousand dollars (\$500,000.00) for injury or death of more than one person in any one year; or (y) a specialist dentist: five hundred thousand dollars (\$500,000.00) for injury or death of any one person and one million dollars (\$1,000,000.00) for injury or death of more than one person in any one year. To the extent tail coverage is required for any period in which Dentist provided services, Dentist shall obtain such insurance at Dentist's own cost and expense.

Executed copies of such policies of insurance or certificates thereof shall be delivered to Guardian upon execution of this Agreement by Dentist and Dentist shall ensure policies provide for the insurers to provide Guardian with thirty (30) days prior written notice of any material change in or termination, cancellation, expiration or non-renewal of any policy of insurance required to be incurred or maintained by Dentist hereunder. Dentist shall further be obligated to furnish renewal certificates or memorandum of insurance for policies required hereunder. As often as any such policy shall expire or terminate, renewal or additional policies shall be procured and maintained by Dentist in like manner and to like extent. Failure to deliver copies of the policies required under this Section (or the certificates thereof) or failure of an insurer to inform Guardian of a reduction in limits, cancellation, or non-renewal of such coverages in accordance with this Section shall constitute grounds for immediate termination of this Agreement by Guardian.

**2.6      Compliance With Laws.** Dentist shall be in compliance with all applicable local, state, and federal laws relating to the provision of services and shall cause all of his/her employees and independent contractors to perform their duties in accordance with all applicable local, state and federal laws and maintain licensure as required by applicable law.

**2.7      Grievance/Complaint Procedures.** Dentist agrees that complaints received by Guardian concerning Dental Services rendered by Dentist will be resolved in accordance with Guardian's grievance procedures contained in the Policies and Procedures.

**2.8      Professional Acceptability.** Nothing contained in this Agreement nor any action or inaction by Guardian or an affiliate of

Guardian shall be construed to require Dentist to provide services in a manner which Dentist deems professionally unacceptable. Dentist shall provide care which is appropriate to the medical and dental needs of Covered Individuals and consistent with treatment provided to other patients. Dentist shall be solely responsible to Covered Individuals for treatment or service. Nothing in this Agreement is intended to create, nor shall it be construed to create, any rights for Guardian to intervene in any manner with, nor shall it render them responsible for, the method or means by which Dentist renders treatment or service to Covered Individuals. Guardian shall not refuse to contract with or compensate for Covered Services provided by Dentist if otherwise eligible solely because Dentist has in good faith: (a) communicated or advocated on behalf of one or more prospective, current or former patients regarding the provisions, terms or requirements of Guardian's health benefit plans as they relate to the needs of such patients; or (b) communicated with one or more prospective, current or former patients with respect to the method by which Dentist is compensated by Guardian for dental services provided to the Covered Individual.

## **III. COMPENSATION AND COVERED INDIVIDUAL PAYMENT LIMITATIONS**

**3.1      Compensation from Applicable Payor.** Billings to the applicable payor for each Plan (each a "Payor Entity") shall include detailed and descriptive dental and patient data and identifying information on forms approved by Guardian or the applicable Payor Entity. For each Listed Service that is rendered to Covered Individuals, Dentist agrees to accept as payment in full the amount listed on the applicable Fee Schedule. Certain of the Listed Services indicated on a Fee Schedule may not be Covered Services under the applicable Plan. The Fee Schedule shall apply even if the applicable Plan is secondary for purposes of coordination of benefits, so that the Payor Entity will not be obligated to reimburse Dentist for Covered Services in excess of the amount on the Fee Schedule. For each Chosen Network, Dentist further agrees to accept the lesser of the charge submitted by Dentist and the amount listed on the Fee Schedule as payment in full for any Listed Service.

**3.2      Compensation from Covered Individual.** Dentist shall collect from the Covered Individual (i) payment for services that are not Covered Services and (ii) the appropriate deductible, co-payment and/or coinsurance for each Covered Service performed. Dentist shall promptly refund any amounts collected in excess of the fee listed in the applicable Fee Schedule of a Chosen Network upon receipt of an explanation of benefits or a notification from Guardian or the Eligible Person of such excess amount.

**3.3      Covered Individual Payment Limitations.** Dentist hereby agrees that in no event, including, but not limited to non-payment by the applicable Payor Entity, payment by the applicable Payor Entity that is other than what Dentist believes to be in accordance with Section 3.1 of this Agreement or is otherwise inadequate, the insolvency of the applicable Payor Entity, breach of this Agreement, or participation in certain but not all of the Networks provided for on the Chosen Networks Addendum, shall Dentist bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Covered Individual, or persons other than the Payor Entity acting on their behalf for Covered Services provided pursuant to this Agreement. Any violation of this Section 3.3 shall be considered a material breach of this Agreement and Guardian shall be entitled to take any and all actions permitted under the terms of this Agreement and/or applicable law. Dentist further agrees that this provision shall survive the termination of this Agreement.

**3.4      Right of Offset.** If, at any time prior to or after payments hereunder by an applicable Payor Entity to Dentist, Guardian identifies overpayments, discrepancies in Covered Services provided, resolution of complaints or other activities that result in amounts due from Dentist to a Payor Entity, Guardian shall have the right to either request and receive a refund from Dentist or offset the amount due to Guardian or a Payor Entity against future payments due to Dentist hereunder. This right to refund or offset shall survive termination of this Agreement.

#### **IV.      TERM AND TERMINATION**

**4.1      Term.** This Agreement shall commence as of the date when this agreement is executed by all parties and will continue for one (1) year and shall automatically be renewed for additional one year terms, unless Guardian or Dentist submits a notice of non-renewal at least ninety (90) days prior to that date or the Agreement is otherwise terminated as provided herein.

**4.2      Termination.**

(A) Except as otherwise provided herein, or as may be required by applicable state law, this Agreement may be terminated at any time by either party upon ninety (90) days advance written notice to the other party. Nonpayment for services by the applicable Payor Entity shall not be a valid reason for not complying with the ninety (90) day notice of cancellation.

(B) Except as otherwise provided herein, or as may be required by applicable state law, Guardian or Dentist may terminate Dentist's right to provide Dental Services in any Chosen Network listed on the Chosen Networks Addendum upon ninety (90) days advance written notice to the other party. Upon such a termination, Dentist shall, if necessary, execute a replacement Chosen Networks Addendum indicating the Chosen Networks under which he/she agrees to continue to provide Dental Services to Covered Individuals. Any such termination shall not terminate this Agreement overall.

(C) Notwithstanding anything contained herein to the contrary, Guardian may terminate this Agreement immediately upon notice to Dentist upon receiving evidence of (i) risk of imminent harm to the health of a Covered Individual; (ii) an action by a state dental or other dental licensing board or other government agency that effectively impairs the dentist's ability to practice medicine or dentistry; (iii) a lapse or material reduction in the insurance coverage required by this Agreement; (iv) conviction of a felony; (v) fraud or malfeasance; (vi) the happening of any of the events set forth in Section 1.1(iv) or the breach of any warranty or representation by Dentist that are set forth in the Agreement, including, but not limited to, the Dentist's representations and warranties set forth in Section 1.2; (vii) a breach of this Agreement; or (viii) the occurrence of any event that pursuant to Guardian's Policies and Procedures, Guardian is permitted to or is required to terminate this Agreement. In addition, this Agreement shall be terminated immediately upon notice to Dentist upon issuance of an order by the applicable state's insurance regulatory agency requiring such termination.

(D) In the event that this Agreement is terminated or expires, Dentist will continue to provide all services in progress as of the date of termination or expiration of this Agreement to Covered Individuals until such services are completed unless Guardian otherwise directs Dentist in writing to the contrary. All such continuing services to Covered Individuals shall be provided consistent with the terms of this Agreement (including, but not limited to complying with the applicable Fee Schedule) and professionally recognized standards of practice. This provision shall expressly survive the termination of this Agreement.

#### **V.      MISCELLANEOUS**

**5.1      Notices.** Any notices required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, prepaid to the first address listed on the execution page attached to this Agreement if sent to Dentist and at the following addresses for Guardian:

The Guardian Life Insurance Company of America  
Dental Network Administration  
PO Box 981574  
El Paso, TX 79998

With copies to:  
The Guardian Life Insurance Company of America  
10 Hudson Yards  
New York, NY 10001  
Attention: General Counsel, Law Department

Any notice mailed to Dentist via regular mail shall be deemed to have been received three days after deposit in the mail, one day if sent via overnight carrier and if hand delivered then on the date received. Either party may, at any time, designate any other address in place of those given above by written notice to the other party.

**5.2      Dentist Access.** Dentist recognizes and agrees that Guardian may, in its sole discretion, (i) offer different fee schedules to certain Dentists; (ii) offer different Plans or Networks to certain Dentists; and (iii) identify, classify or distinguish between Dentists in various ways based on selected factors, including, but not limited to, the benefits that Covered Individuals may receive in relation to a particular Dentist. Notwithstanding any written or oral representation to the contrary, Dentist understands that Guardian cannot and does neither guarantee that a minimum number of Covered Individuals will access Dentist nor that Dentist will be accessed by any Covered Individuals.

**5.3      Complete Agreement/Confidentiality.** This Agreement, including exhibits or schedules, addenda, and any amendments thereto, and the Policies and Procedures together with any amendments thereto, comprise the Participating Dentist Agreement. Dentist shall not, directly or indirectly, disclose or use any of the terms contained in this Agreement (including any exhibits, addenda, or schedules attached hereto), the Policies and Procedures or any other documents or information provided by Guardian to Dentist unless such disclosure or use is required by law. This Section shall survive termination of this Agreement.

**5.4 Amendments.** Unless otherwise provided herein, this Agreement and/or its attachments, including but not limited to the Chosen Networks Addendum, the Fee Schedule(s) and the Policies and Procedures, may be amended by Guardian at any time upon thirty (30) days prior written notice to Dentist. If an amendment is not acceptable to Dentist, he/she must reject such amendment by providing written notice to Guardian at the addresses set forth in Section 5.1 of this Agreement within such thirty (30) day period. In the absence of such notice of rejection by Dentist to Guardian, Dentist will be deemed to have accepted such amendment as of its stated effective date. If Dentist rejects the amendment, Guardian shall have the right to continue the terms of this Agreement without giving effect to the proposed amendment. Guardian reserves the right to immediately amend this Agreement upon notice to Dentist with respect to an amendment which it reasonably believes is required by applicable law or regulation.

**5.5 Use of Name.**

(i) Except as provided in this paragraph, Dentist shall not use Guardian's name or logo in any advertising or marketing materials or in any mailing without the prior written consent of Guardian, including, but not limited to, including any references to Guardian in any website or otherwise in connection with the internet or including any link to the Guardian website in any website created, designed, managed or operated by or for the Dentist (see Dentist Manual for additional information). Notwithstanding the foregoing, by its execution of this Agreement, Guardian consents to use of its name and logo by Dentist in the Dentist's printed office marketing materials and direct mailing (not email) to Dentist's patient or prospective patients; provided, however, that (A) such usage must be limited to use in connection with reference to Dentist's participation in the Chosen Networks, (B) usage must be stopped immediately upon any termination of this Agreement or other termination of Dentist's participation in the Plans, and (C) Dentist must remove immediately (and within no more than 5 business days of any termination of Dentist participation) all references to Guardian or use of the Guardian logo from any office marketing materials or direct mailings upon termination of this Agreement or other termination of Dentist participation in the Chosen Networks.

(ii) Dentist agrees that his/her name, office telephone number, address, facility name and specialty, if any, may be included in literature distributed to existing or potential Covered Individuals, other dentists or to further the legitimate business objectives of Guardian or the applicable Payor Entity, including but not limited to Internet and printed directories.

**5.6 Arbitration.** All disputes, controversies, or claims arising out of or relating to the performance or interpretation of any terms of this Agreement shall be submitted within New York County (unless another location is agreed to by the parties) to a Board of Arbitrators consisting of one (1) member, under the commercial rules and regulations of the American Arbitration Association. Any award rendered by the arbitrator shall be final and binding upon the parties hereto and judgment upon any such award may be entered in any court having jurisdiction thereof. Each party shall pay its own fees and costs relating to any arbitration proceedings, including attorney's fees, except that the fees and expenses of the arbitrator shall be borne equally by the parties. Notwithstanding anything else herein, unless Guardian expressly agrees, this provision shall not require Guardian to arbitrate disputes involving multiple plaintiffs or complainants, including, but not limited to, class arbitration.

**5.7 Miscellaneous.** Unless otherwise prohibited by applicable law: (i) in the event that any portion of this Agreement is found to be void or illegal, the validity or enforceability of any other portion shall not be affected; (ii) the waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof; (iii) this Agreement shall be construed and governed by the laws of the State of New York; (iv) this Agreement may be executed in any number of counterparts which, when read together, shall constitute one instrument; (v) Dentist hereby agrees to indemnify and hold Guardian (including any of its employees, officers, directors and agents) harmless from any and all claims, demands, damages, liabilities and costs incurred by Guardian, including reasonable attorneys' fees, arising out of or in connection with the performance of any acts or omissions by Dentist or his/her employees or agents; and (vi) this Agreement shall not be assigned by the Dentist without the express written consent of Guardian. Guardian may assign this Agreement to any entity in order to further Guardian's legitimate business objectives.

**5.8 Other Provisions.** Notwithstanding anything to the contrary set forth herein, Dentist and Guardian agree to the provisions set forth on Exhibit B, which provisions are hereby incorporated by reference herein in their entirety.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the date when Guardian executes this Agreement.

THE GUARDIAN LIFE INSURANCE  
COMPANY OF AMERICA

By: \_\_\_\_\_

Vice President

Date: \_\_\_\_\_

Please list all addresses where Dentist shall provide dental services to Covered Individuals. Use a separate sheet of paper, if needed, for additional locations.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Tel No.: \_\_\_\_\_

Fax No.: \_\_\_\_\_

DENTIST

By: \_\_\_\_\_  
(Signature)

SIGN  
HERE

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Tel. No.: \_\_\_\_\_

Fax No.: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Tel No.: \_\_\_\_\_

Fax No.: \_\_\_\_\_

ADDRESS  
REQUIRED



**DentalGuard Networks**  
P.O. Box 981574  
El Paso, TX 79998-1574  
1-800-890-4774

**CHOSEN NETWORKS ADDENDUM**

(page intentionally left blank)



**DentalGuard Networks**  
P.O. Box 981574  
El Paso, TX 79998-1574  
1-800-890-4774

**CHOSEN NETWORKS ADDENDUM**

**(page intentionally left blank)**



**DentalGuard Networks**  
P.O. Box 981574  
El Paso, TX 79998-1574  
1-800-890-4774

## EXHIBIT B

### STATE SPECIFIC PROVISIONS

1. Section 1.1(iv), Notification Requirements, of the Agreement shall be amended by replacing the phrase "any state" with the phrase "the State of New Jersey".

2. Section 1.2, Representations and Warranties, of the Agreement shall be amended by replacing the phrase "each state in which he/she practices" with the phrase "the State of New Jersey".

3. Notwithstanding anything to the contrary herein, Section 2.5, Liability Insurance, of the Agreement shall be amended by adding the following:

Pursuant to the State of New Jersey insurance regulations, Dentist shall, at Dentist's expense, maintain a policy of professional liability insurance in amounts not less than one million dollars (\$1,000,000.00) for injury or death of any one person, and not less than three million dollars (\$3,000,000.00) for injury or death of more than one person, in any one year throughout the term of this Agreement.

4. Section 2.4, Dental Records, of the Agreement shall be amended by adding the following:

Dentist's activities and records relevant to the provision of health care services may be monitored from time to time by certain parties.

5. Notwithstanding anything to the contrary herein, with respect to Section 3.1, Compensation from Applicable Payor, of the Agreement, the parties shall abide by the coordination of benefits rules set forth at N.J.A.C. 11:4-28.7(c).

6. A new Section 3.5, Non-Covered Services, shall be added as follows:

Non-Covered Services. If a procedure is not reimbursable by Guardian ("Non-Covered Service") due to the application of any limits, exclusions or maximums under the appropriate Plan, Dentist may charge the Covered Individual the applicable fee for such Non-Covered Service provided that prior to performing such procedure the Dentist clearly informs the Covered Individual that Guardian may not cover or continue to cover a specific service or services.

7. A new Section 3.6, Claim Disputes, shall be added as follows:

Claim Disputes. In the event that Dentist disputes the payment of a claim by Guardian, Dentist may, within ninety (90) calendar days of receipt of such payment or denial, request in writing that Guardian review such determination. Any such request shall be on a form prescribed by the New Jersey Commissioner of Banking and Insurance and directed to Guardian's Grievance Department at P.O. Box 2457, Spokane, WA 99210-2457. Any such request shall include the substantiating documentation described in the form prescribed by the Commissioner of Banking and Insurance and copies of all relevant dental records, radiographs and statements from the dentist or the office personnel. Guardian shall respond to any such request in writing within thirty (30) calendar days of receipt thereof. Guardian's written decision shall include: (i) the names, titles and qualifying credentials of the persons participating in such review; (ii) a statement of Dentist's grievance; (iii) the decision of the reviewers, along with a detailed explanation of the contractual and/or medical (or dental) basis for such decisions; (iv) a description of the evidence or documentation which supports such decision; and (v) if the decision is adverse, a description of the method for referring the dispute to arbitration using the Program for Independent Claims Payment Arbitration (PICPA), provided that disputes concerning "Adverse Dental Decisions" as defined in N.J.S.A. 17:48G-2 shall not be submitted to binding arbitration. All reviews will be conducted pursuant to applicable law and regulation, including but not limited to, N.J.S.A. 17B:27-44.2 to the extent applicable. Except with respect to disputes regarding an Adverse Dental Decision, any additional review shall be conducted in accordance with the arbitration process set forth below.

Dentist may file a request for Arbitration of a Disputed Claim with The Program for Independent Claims Payment Arbitration (PICPA) on or before the ninetieth (90th) calendar day after receiving a determination on a claim payment internal appeal or if Guardian fails to respond within thirty (30) calendar days to an internal appeal. The amount in dispute must be one thousand dollars (\$1,000) or more. Dentist is permitted to aggregate disputed claim amounts to reach the one thousand dollar (\$1,000) threshold. Any award rendered by the arbitrator shall be final and binding upon the parties and judgment upon any such award may be entered in any court having jurisdiction thereof. Each party shall pay its own fees and costs relating to any arbitration proceedings, including attorney's fees, except that the fees and expenses of the Arbitration Process shall be borne equally by the parties. Dentist will submit one half of the arbitration Process fee when submitting the PICPA application. By signing this Agreement, Dentist agrees that the outcome of any such proceeding shall be final and binding on the parties hereto, then in accordance with N.J.A.C 17:48G-2:

a. Guardian may make dental decisions in connection with the processing or payment of dental claims or otherwise in the course of its dental benefit administration activity. Dental decisions made by Guardian shall be consistent with the following:

(1) an initial adverse dental decision shall be made by a dentist duly licensed in New Jersey or another state;  
(2) if a treating Dentist questions the adverse dental decision and specifies in writing the basis of the disagreement with the adverse dental decision, Guardian, within 30 days shall:

(a) designate a reviewing dentist who is duly licensed in New Jersey or who has been issued a limited registration certificate as permitted by law; and

(b) notify the treating Dentist in writing promptly of the name and address where the reviewing dentist can be contacted and the telephone number which can be used to contact the reviewing dentist;

(3) if an agreement is not reached within a reasonable period of time, not to exceed 30 days from Guardian's notice issued pursuant to subparagraph (b) of this paragraph (2), Guardian shall make its decision and communicate the results of the reviewing dentist's dental decision to the treating Dentist.

b. Within 14 days of a written request by the treating Dentist, or the patient or the patient's authorized representative, for the basis of an adverse dental decision by a reviewing dentist, provided to the treating Dentist pursuant to paragraph (3), above, Guardian shall send a written notice containing the full name, address and telephone number of the reviewing dentist and a narrative statement specifically identifying the basis for the decision

8. Section 4.2(C), Termination, of the Agreement shall be amended by replacing the phrase "applicable state's insurance regulatory agency" with the phrase "New Jersey Department of Banking and Insurance"

9. Dentists terminated under Section 4.2, Termination, of the Agreement shall be issued a written statement setting forth the reason(s) for the termination, and the procedures for obtaining such a written statement, in the event that the written notice of termination does not include a statement setting forth the reason(s) for the termination.

Guardian also agrees that Dentist shall have the right to request a fair hearing within ten (10) business days following the date of notice of termination. Hearings will be conducted within thirty (30) calendar days following receipt of a Dentist's request before a panel appointed by Guardian. The appointed panel will consist of no less than three (3) people, at least one of whom shall be a clinical peer of the same discipline as terminated Dentist. Guardian shall not preclude Dentist from being present at the hearing, nor preclude Dentist from being represented by counsel at the hearing.

The panel shall render a decision on the matter in writing within thirty (30) calendar days of the close of the hearing unless the panel provides notice of a need for an extension. The panel's decision shall set forth the relevant Agreement provisions and the facts upon which Guardian and Dentist have relied on at the hearing, and shall specify the reasons for its recommendation of termination, reinstatement, or provisional reinstatement. In the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of duration of the Agreement at issue. In the event that the panel recommends that the Dentist be terminated, Guardian shall then provide notice of termination to covered persons in accordance with NJAC 11:24A-4.8(c), as necessary.

The right to a hearing will not apply when Dentist's termination occurs on the date of renewal or anniversary of the Agreement, or is based on breach or alleged fraud, or because, in the opinion of Guardian's Dental Director, Dentist presents an imminent danger to one (1) or more covered persons, or the public health, safety or welfare.

10. Notwithstanding the terms of Section 4.2, Termination, of the Agreement, Guardian shall not be permitted to terminate or otherwise penalize Dentist because of complaints or appeals filed by Dentist.

11. Section 5.4, Amendments, of the Agreement shall be amended by adding the following:

This Agreement, and all subsequent amendments thereto, are subject to prior approval of the New Jersey Department of Banking and Insurance and may not be effectuated without such approval.

12. Section 5.6, Arbitration, of the Agreement shall be amended by deleting the section in its entirety and replacing it with the following:

Arbitration. Except with respect to Disputed Claims as defined in Section 3.6 of the Agreement and any disputes concerning Adverse Dental Decisions as defined in N.J.S.A. 17:48G-2, all disputes, controversies, or claims arising out of or relating to the performance or interpretation of any terms of this Agreement, shall be submitted within Bergen County (unless another location is agreed to by the parties) to a Board of Arbitrators consisting of one (1) member, under the commercial rules and regulations of the American Arbitration Association. Any award rendered by the arbitrator shall be issued within thirty (30) business days of receipt of all documentation necessary to complete the review. Any award rendered by the arbitrator shall be final and binding upon the parties hereto and judgment upon any such award may be entered in any court having jurisdiction thereof. Each party shall pay its own fees and costs relating to any arbitration proceedings, including attorney's fees, except that the fees and expenses of the arbitrator shall be borne equally by the parties. Notwithstanding anything else herein, unless Guardian expressly agrees, this provision shall not require Guardian to arbitrate disputes involving multiple plaintiffs or complainants, including, but not limited to, class arbitration.

13. Section 5.7(iii), Miscellaneous, of the Agreement shall be amended by replacing the phrase "New York" with the phrase "New Jersey".

14. Dentist is hereby required to cooperate with Guardian's comprehensive credentialing and recredentialing requirements contained in the Policies and Procedures. Guardian will complete the initial credentialing process within ninety (90) calendar days of receipt of all necessary requested information, or if no information needs to be requested from Dentist, within one-hundred and twenty (120) calendar days of receipt of membership application. Guardian will recredential participating Dentists every three (3) years.

15. Dentist has the right and obligation to communicate openly with all Covered Individuals regarding diagnostic tests and treatment options.

16. An overdue payment on a claim for a covered service shall bear simple interest at the rate of 12% per annum, and Guardian shall pay the accrued interest to the participating Dentist at the time the overdue payment is made. The rate of interest and the manner by which payment shall be made shall be in accordance with NJSA 17B:27-44.2, and as may be amended from time to time by the NJ Department of Banking and Insurance.

17. Dentist may submit and seek resolution of complaints and grievances, separate and apart from those of a Covered Individual, including complaints addressing compensation and other claim issues, by writing Guardian's Grievance Department at PO Box 2457, Spokane, Washington, 99210-2457 or via facsimile at 1-509-468-6399; or by contacting Guardian's Customer Response Unit at 1-800-541-7846. Guardian shall provide Dentist with written notification of decision within thirty (30) calendar days.

18. Any sections of the Agreement that conflict with State or Federal law are effectively amended to conform with the requirements of the State or Federal law.

19. Guardian is hereby a third party beneficiary of the Agreement, with privity of contract, and a right to enforce the provisions of the Agreement.

Request for Taxpayer  
Identification Number and Certification► Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.Give Form to the  
requester. Do not  
send to the IRS.Print or type.  
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
2 Business name/disregarded entity name, if different from above	
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.	
<input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► <b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is <b>not</b> disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ►	
4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):	
Exempt payee code (if any) _____	
Exemption from FATCA reporting code (if any) _____	
(Applies to accounts maintained outside the U.S.)	
5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6 City, state, and ZIP code	
7 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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
-       -

or

Employer identification number
-

**Part II Certification**

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**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 for Part II, later.

Sign Here	Signature of U.S. person ►
-----------	-------------------------------

Date ►

**General Instructions**

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

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

**Purpose of Form**

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.*