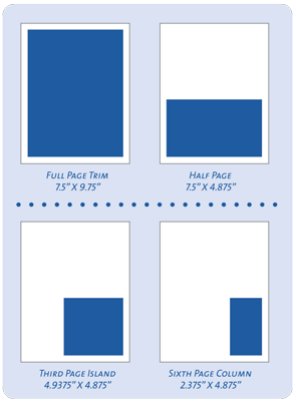
NEBRASKA DENTAL ASSOCIATION
2021 Display Advertisement Placement Order

AD SIZE:



CONTACT INFORMATION:

Company Name _____
Contact Person: _____
Address_____
City_____ State_____ Zip_____
Phone _____Fax: _____Email: _____
Signature: _____
Date: _____

ADVERTISING RATES:

Display Ad Rates

Size	1x 4C	2x 4C	4x 4C
Full	$625	$550	$525
Half	$350	$275	$250
Third	$275	$200	$175
Sixth	$250	$125	$100

4 ISSUES TO RUN IN:

- ❑ January/February/March (mailed to members)
- ❑ April/May/June (emailed to members)
- ❑ July/August/September (mailed to members)
- ❑ October/November/December (emailed to members)

ART:
Electronic file or camera-ready art accepted. Electronic files may be submitted via e-mail or on a disk. The NDA currently accepts the following electronic file types: Quark Express, Microsoft Word, and Adobe Acrobat (PDF). When creating PDF files, please embed all fonts and graphics. When possible, please convert all Microsoft Office or word processing documents into pdf files. A printout must accompany all electronic files. The advertiser is responsible for the quality of the ad submitted.

TERMS:

- Cancellations will not be accepted after the 25th of the month prior to scheduled publication date.
- All copy is subject to the approval of the Nebraska Dental Association. The advertiser herein also agrees to indemnify and defend the NDA from any and all liability for content of advertisements.
- All artwork needs to be in the hands of the NDA by the 20th of the month PRIOR to publication.

Payment Terms:

Ad Size: _____
Ad Rate: $_____ # of Times: _____
Ad Rate x # of Times = $_____
Total Due: $_____
(Ads must be paid in full prior to publication. No monthly billings will be sent for display ads)

Please fax or mail payment to:
Nebraska Dental Association
7160 South 29th Street, Suite 1
Lincoln, Nebraska, 68516
402-476-2641 (FAX)

Credit Card Type:

- ❑ VISA
- ❑ Mastercard
- ❑ Discover
- ❑ American Express

Name on Credit Card:
_____
Credit Card # _____
Exp. Date: _____ (CVN) (*3 digit number located on the back of card*) _____
Billing Address & Zip Code:
_____
_____
Authorized Signature _____ Date: _____

For further information contact:
Jody Cameron at the Nebraska Dental Association
7160 South 29th Street, Suite 1
Lincoln, NE. 68516
402-476-1704 (PHONE) 402-476-2641 (FAX)
jody@allophone.com (EMAIL) / www.nedental.org (WEBSITE)