Dental Savings Plan Enrollment

Personal Information

Please Print Legibly

Name: ____
(last, first, middle initial)
Date of Birth:___________________ Sex:_______ SS #:_____________________
Address:____
City, State, Zip: ____
Phone:________________________ Email: ______________________________

Spouse Information

Name: ____
(last, first, middle initial)
Date of Birth:___________________ Sex:_______ SS #:_____________________

Children Information

Name: ____
(last, first, middle initial)
Date of Birth:___________________ Sex:_______ SS #:_____________________

Children Information

Name: ____
(last, first, middle initial)
Date of Birth:___________________ Sex:_______ SS #:_____________________

I have read the brochure on the Savings Plan, and understand the benefits, limitations and requirements. I agree to the terms as written, and am aware that this is a Non Refundable Plan. I understand that any authorized payment plans do require a credit card to be automatically drafted, and I will immediately advise the office if there are any changes with the card on file. If I fail to advise the office about changes in a timely manner, I have been advised that there could be additional NSF fees applied to my account, and I could ultimately forfeit my plan. I also understand that I must advise the office prior to plan expiration if I would like to cancel my auto renewal for the next year's savings plan.

Signature: ______________________________
Date: ______________

For Office Use Only: Date: __________ Employee: _____________
Total Plan: _________
Paid in Full: ________ Chk ______ Cash_____ CC_______
Payment Plan: CC Type: _______________ Exp Date: ___________
Terms of Payment Plan:_____________________________________
____

Please Initial by Chosen Plan

____Individual ……. $399/yr
____Dual Plan………$699/yr
____Family Plan(3) ..$999/yr
____FamilyPlan(4)…$1149/yr
____($150/person over 4)