Dental Savings Plan Enrollment Form

~ For office use only ~

Effective Dates

Starting *Ending*

To apply for membership please complete all questions.

Name: _____ _____
First Name Last Name

Address: _____
Street Address

_____
Street Address (line 2)

_____ _____ _____
City State Zip Code

Contact Number: _____ - _____
Area Code Phone Number

Application/Plan Type:

○ Single ***$380.00***

○ Dual (2 members only) ***$725.00***

○ Family (Up to 3 members) ***$1,075.00***

○ Each additional family members ***$305.00*** (4 to 6 members)

○ Each additional family members ***$255.00*** (7 or more members)

Additional Member Name(s):

1. _____ *2.* _____

1. _____ *2.* _____

3. _____

4. _____ *5.* _____

6. _____

7. _____ *8.* _____

9. _____ *10.* _____ .

If paying by Credit Card, please provide the following Information:

☐ *MasterCard* ☐ *Visa* ☐ *Discover* *Account #:* _____

Expiration Date: _____ *3 digit Security Code:* _____

Name on the card: _____

Signature **Date**