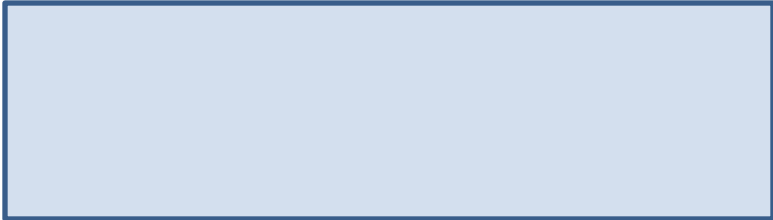




# Dental Savings Plan Enrollment Form



Effective Dates

~ For office use only ~

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:** **Additional Member Name(s):**

- Single **\$365.00**
- Dual (2 members only) **\$700.00** 1. \_\_\_\_\_ 2. \_\_\_\_\_
- Family (Up to 3 members) **\$1,040.00** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_
- Each additional family members **\$292.00** 4. \_\_\_\_\_ 5. \_\_\_\_\_  
(4 to 6 members) 6. \_\_\_\_\_
- Each additional family members **\$245.00** 7. \_\_\_\_\_ 8. \_\_\_\_\_  
(7 or more members) 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 \_\_\_\_\_