**Dental** **One**

**Dental Savings Plan Application**

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

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_Zipcode\_\_\_\_\_\_

Covered Plan Members:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Birth Date | Relationship | Plan (circle one) |
|  | / / | Initial Member | Traditional/Periodontal |
|  | / / | Additional Member | Traditional/Periodontal |
|  | / / | Additional Member | Traditional/Periodontal |
|  | / / | Additional Member | Traditional/Periodontal |
|  | / / | Additional Member | Traditional/Periodontal |
|  | / / | Additional Member | Traditional/Periodontal |

**Traditional Plan** **Periodontal Maintenance Plan**

Initial Family Member - $365 Initial Family Member -$620

Each Additional Family Member - $340 Each Additional Family Member - $595

Payment Method

* Check
* Cash
* Debit/Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp Date\_\_\_\_\_\_\_\_\_\_\_\_\_CVC\_\_\_\_\_\_\_\_
* Care Credit #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp Date\_\_\_\_\_\_\_\_\_\_\_\_\_CVC\_\_\_\_\_\_\_\_

**By signing below, I acknowledge that I have read the brochure and understand the plan details and limitations.**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of plan holder)

**I authorize Dental One to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the discount Plan. Dental One will notify me when the plan is renewed for my record. If I choose to discontinue participating in the discount plan, I will notify Dental One one month prior to my anniversary renewal date.**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of plan holder)

\*Annual fee is required at enrollment and is non-refundable. Dental One reserves the right to modify, change, or discontinue the In-office Dental Savings Plan, fees, term, and services at the company’s option upon written notice from Dental One prior to your Anniversary renewal date.