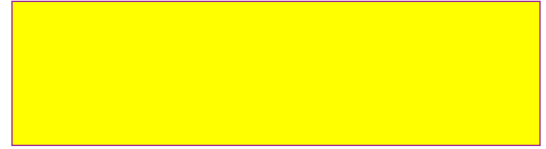


# Dental Savings Plan Application



~For official use only~

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth (D/M/Y): \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

Island: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Annual Enrollment Fees:

<b>INDIVIDUAL</b> <input type="checkbox"/> <b>US\$100.00</b>	<b>FAMILY (UP TO 3)</b> <input type="checkbox"/> <b>US\$150.00</b> <b>FAMILY (UP TO 6)</b> <input type="checkbox"/> <b>US\$200.00</b> <b>FAMILY (UP TO 9)</b> <input type="checkbox"/> <b>US\$250.00</b>	<b>CORPORATE</b> <input type="checkbox"/> <b>US\$80.00 (10 or More)</b> <b>SENIOR</b> <input type="checkbox"/> <b>US\$60 (75 and over)</b>
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(Enrollment fee for each additional member is \$30)

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

### Additional Members:

Name	DOB	Email	Member ID
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____

### Payment Method:

- Check
- Cash
- Debit/Credit Card

By signing below, I acknowledge I have read the Paradise Smiles Ltd. Dental Savings Plan information provided to me and understand the plan details and limitations.

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

(Parent signature required if member is under the age of 18)