Dental Savings Plan Application

~For official use only~

Last Name: ___________________________ First Name: ________________________ MI: _______

Date of Birth: ________________________ Email: ____

Home Address: ____

City: _________________________________ Phone #: ______________________________________

Annual Enrollment Fees:

BASIC □ US$80.00 **PLUS □ US$160.00**	**FAMILY (UP TO 3) □ US$150.00** **FAMILY (UP TO 6) □ US$250.00** **FAMILY (UP TO 9) □ US$500.00**	**CORPORATE □ US$80.00 (10 or More)**

Effective Date: ___________________________ ***End Date:*** ________________________________

Additional Members:

Name	***DOB***	***Member ID***	***Plan***

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 19)