# Smile Saver Dental Membership

## *Individual and Family Plan Enrollment Form*

| Team Member's Initials | | Name – Last First MI | | Phone ( ) | |
|---|---|---|---|---|---|
| Sex (Circle one) M or F | Date of Birth MO DAY YR | Home Address – Number and Street | City | State | Zip |

**Check the type of contract and list all covered dependents below, if applicable:**

☐ **Individual $455** ☐ **Each Additional Individual $405**

**COVERED DEPENDENTS** List all Covered Dependents below. If additional space is required, attach a list to this form.

| Last First MI | | Date of Birth MO DAY YR | | | Sex M | F |
|---|---|---|---|---|---|---|
| Spouse | | | | | | |
| Dependent | | | | | | |
| Dependent | | | | | | |
| Dependent | | | | | | |
| Dependent | | | | | | |

**Dependents covered through the end of the year in which they turn age 25.**

**Please select one of the three payment methods below. Please provide all necessary information.**

**1.** ☐ **Credit Card –** ☐ **Annual**

**Visa** ☐ ☐ **MasterCard** ☐

Card Number _____

Expiration Date _____

Signature _____

**2.** ☐ **Paper Check or Money Order – Annual premium only**

**(Please include your check or money order with this form.)**

**3.**☐ **Cash**

***I acknowledge that I have read the provisions of this enrollment form and I expressly accept such provisions as a condition of coverage. I understand that my membership is for a 12 month period and on my anniversary date I can renew or cancel. I understand that this contract is non-refundable once purchased and can't be used at any other office.***

***Signature:***

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***Date:***

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