IN-OFFICE SAVINGS PLAN ENROLLMENT FORM

Your Profile

Name:		
Address:		
City:	State:	Zip:
Phone: ( )	Alt. Phone: ( )	
E-Mail:		

Spouse

Name:		
Address:		
City:	State:	Zip:
Phone: ( )	Alt. Phone: ( )	
E-Mail:		

Dependent Children

Name:	DOB:	
Name:	DOB:	
Name:	DOB:	
Name:	DOB:	
Name:	DOB:	

Member Signature:____	Date:_______________

Please mail this completed application with the appropriate payment (check or Credit Card) to:

North East Dental Arts
93 W. Main Street
North East, PA 16428

Single	$329
Dual (2)	$608
Family (3)	$887
Each Additional	$297/each

Please make check payable to: North East Dental Arts

If using Credit Card for payment, please provide:

Credit Card Number: ____________________________________
Expiration________________3-digit code_________

Please circle type of card using:
Visa MasterCard Discover American Express

Authorization Signature ______________________________

Please Print Name __________________________________