NORTH EAST Dental Arts EST. 1998

DENTAL SAVINGS PLAN ENROLLMENT FORM

MEMBER PROFILE

Name: _____ Date of Birth: _____

Name of Parent/Guardian: (if member is a minor) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Alt. Phone: ( ) _____

Email: _____

Plan Selection: ☐ **Standard: $479 per year** ☐ **Children: $379 per year** ☐ **Periodontal: $549 per year**

_____ / _____

Member Signature (Parent or Guardian if member is a minor) Date

By signing this Dental Savings Plan Enrollment Form, you are acknowledging full understanding of the plan chosen above and agree to all guidelines, exclusions and limitations. Plans are non-refundable, non-transferable.

PAYMENT Full payment is due at the time of Enrollment.

Please make Checks payable to: **North East Dental Arts** and mail your payment to:

North East Dental Arts
Re: DENTAL SAVINGS PLAN
90 E. Main Street
North East, PA 16428

For Credit Card payment, please provide:

Name as it appears on card: _____

Credit Card Number: _____

Expiration: _____ Security Code: _____

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

_____/_____

Authorized Signature Please Print Name

TO BE COMPLETED BY NORTH EAST DENTAL ARTS OFFICE

MEMBER ID #: _____ **CHECK #:** _____