Select Dental Plan

REGISTRATION FORM

(All information confidential.)

Last Name: _____ First: _____ MI: ___ SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Birth Date: _____ Employer & Title: _____

List Covered Dependents: (Eligible dependents include only spouses & children under the age of 23.)

Name:	Birth Date:	Relationship:	Name:	Birth Date:	Relationship:

Payment Method:

Yearly Discount Plan ($250 + $200 per additional member - savings up to $50 per member vs. Monthly Plan)

Total: _____ per year

Cash: _____ Check: _____

Credit Card #: _____ Exp. Date: _____ Billing Zip Code: _____ CVC: ____

Card Type: MC ___ VISA ___ American Express ___ Discover ___ Care Credit ___

Signature: _____ Date: _____

Monthly Discount Plan ($25/month + $20/month per additional member.)

Total: _____ per month

Cash: _____ Check: _____

Credit Card #: _____ Exp. Date: _____ Billing Zip Code: _____ CVC: ____

Card Type: MC ___ VISA ___ American Express ___ Discover ___ Care Credit ___

Signature: _____ Date: _____

(Please see "Terms and Conditions" plus member signature on reverse side.)

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