



JARRETTSVILLE FAMILY DENTAL

Dental Savings Plan Application Form

Primary Plan Holder:

Effective Date: _____

FOR OFFICE USE ONLY

First Name: _____ Last Name: _____ Middle Initial: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone #: _____ E-mail: _____ Birthdate: _____

Annual Membership Cost \$299

Additional Family Members to be Covered:

Additional Cost per Member:

Name: _____ Relationship: _____ Birthdate: _____ Add: **\$276**

Name: _____ Relationship: _____ Birthdate: _____ Add: **\$177**

Name: _____ Relationship: _____ Birthdate: _____ Add: **\$165**

Name: _____ Relationship: _____ Birthdate: _____ Add: **\$110**

*** Total Amount Due:** _____

Payment Method:

Cash (in-office only**)

** If paying with cash, please return this application to our office in person. Do not mail cash payments.

Check (make checks payable to Jarrettsville Family Dental and enclose check with application)

Credit Card #: _____ Exp. Date: _____ CVC: _____

Set my account listed above to Auto Draft***

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental Savings Plan are NON-REFUNDABLE. Jarrettsville Family Dental reserves the right to modify, change, or discontinue the Dental Savings Plan, terms, fees, and services at the company's discretion upon written notice from Jarrettsville Family Dental prior to your anniversary renewal date.

Auto-Renewal Program: Sign up now and save 5% off next year's premium!

*** I, _____, authorize Jarrettsville Family Dental to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Jarrettsville Family Dental will notify me when the plan is renewed, for my records. If I choose to discontinue participating in the dental savings plan, I will notify Jarrettsville Family Dental one month prior to my anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card info) to your preferred dental office location:

2000 Schuster Road Jarrettsville Maryland 21084

By signing below, I acknowledge that I have read the Dental Savings Plan brochure and understand the plan details, benefits, and limitations.

Member Signature: _____ Date: _____