



## 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 #: \_\_\_\_\_ Email: \_\_\_\_\_ 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 Dental Implants of Ocala 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 is NON-REFUNDABLE. Dental Implants of Ocala reserves the right to modify, change, or discontinue the Dental Savings Plan, Savings Plan Plus, terms, fees, and services at the company's discretion upon written notice from Dental Implants of Ocala prior to your anniversary renewal date.

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

\*\*\*I, \_\_\_\_\_, authorize Dental Implants of Ocala to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the Dental Savings Plan. Dental Implants of Ocala 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 Dental Implants of Ocala one month prior to my anniversary renewal date.

**Please mail this completed application with appropriate payment (check or credit card info) to our dental office location:  
Dental Implants of Ocala - 7550 SW 61st Ave, #2 Ocala, FL 34476**

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: \_\_\_\_\_