**Kelly Dental**

General, Family, & Cosmetic Dentistry

# Dental Savings Plan Application Form

**Plan Effective Date:** ______________
*(for office use only)*

**PRIMARY PLAN HOLDER:**

First Name: ____________________ Last Name: ____________________ Middle Initial: _______ Social Security #:____________________

Address: _________________________________ City: ________________________________ State: _______ Zip:____________________

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:** ____________

*Annual fee is required at enrollment and cannot be financed. Membership fees for the Dental Savings Plan is NON-REFUNDABLE. Kelly 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 Kelly Dental prior to the anniversary renewal date.

**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 Kelly Dental and enclose check with application.)*

☐ Credit Card #: _______________________________________________ Exp. Date: ______________________ CVC: ______________

☐ Set my card listed above to Auto-Renewal***

**AUTO-RENEWAL PROGRAM: SIGN UP NOW AND SAVE 5% OFF NEXT YEAR'S PREMIUM!**

*** I, ________________________________________, authorize Kelly Dental to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Kelly 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 Kelly Dental one month prior to my anniversary renewal date.

**Please mail this completed application with appropriate payment (check or card info) to Kelly Dental:**

**1655 S Enterprise Ave A-3, Springfield, MO 65804**

*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: ________________________________