In-House Dental Savings Plan

MEMBERSHIP APPLICATION

☐ NEW ENROLLMENT ☐ RENEWAL

PRIMARY MEMBER

Name: _____ Birthday: _____ Mobile Number: _____ Sex (M/F)

Mailing Address: _____ Email Address _____

Billing Address: _____ Other Contact Number:_____

LIST OF COVERED DEPENDENTS:

Name	Birthday	Age	Relationship	Name	Birthday	Age	Relationship

PLAN (One Year Membership Plan) tax 4.712% ☐ Annual Discount Plan ☐ Monthly Plan ($25/mo + $20/mo additional member

	☐ Individual	☐ Adult ___ (additional)	☐ Child ___ (under 13yo)
	$ _____ + tax	$ _____ + tax	$ _____ + tax
Total:	**$_____**	**$ _____**	**$ _____**

PAYMENT IFORMATION

☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Other _____

Card Number: _____ CVV: _____ Expiration: _____

Card Holder Name if different from applicant: _____ Date: _____

Relationship with card holder: _____ Card Holder Signature: _____

TERMS AND LIMITATIONS OF THE PLAN

As a PFD In-House Dental Savings Plan Member, I hereby agree and understand: a) payments are due at the time services are received; b) that PFD Dental Savings Plan is not an insurance policy and cannot be combined with any other dental/health insurance; c) that if referred to a specialist, they will NOT offer this discount; d) that this plan is non-transferrable- family members cannot be substituted in for another family member; e) the plan is non-refundable – no refunds if chooses not to use the plan; f) rates are subject to change at any time.

The plan will automatically renew after one year. To cancel auto-renewal please call us or write a cancellation request 1 month before renewal date.

Signature of Applicant: _____ Date: _____

To be filled up by PFD employee

Enrolled by : _____ Date: _____ Branch: _____

Membership Start Date: _____ Renew On: _____ Total Payment : $_____

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