Savings Plan Application

Effective Date:_____________

Last Name:_____________________ First Name:_____________________ MI:_____

Date of Birth____________________

Home Address___________________________
City_______________ State______________ Zip__________________

Check One:

☐ **Traditional Plan $289**

☐ **Perio Maintenance Plan $545**

Payment Method

☐ Check

☐ Cash

☐ Debit/Credit Card #____________________ Exp. Date:__________ CVC:________

☐ Care Credit

Annual fee is required at the time of enrollment and is non-refundable. The office of dh Dental Care reserves the right to modify, change, or discontinue the Savings Plan fees, terms, and services at the company's discretion upon written notice from the office of dh Dental Care prior to your anniversary renewal date

By signing below, I acknowledge I have read the dh Dental Care Plan information provided to me and understand the plan details and limitations

Signature____ Date_____________
(parent signature required if member is under the age of 18)