Dental Savings Plan Application

~For official use only~

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Email: _____

Home Address: _____

City: Select Island Phone #: _____

Annual Enrollment Fee:
ANNUAL□ US$84.00 MONTHLY □ US$7.00

Effective Date: _____ End Date: _____

Additional Members:

Name	*DOB*	*Member ID*	*Plan*

Payment Method:

□ Check
□ Cash
□ Debit/Credit Card

By signing below, I acknowledge I have read the Paradise Smiles Ltd. Dental Savings Plan information provided to me and understand the plan details and limitations.

Signature_____ Date_____

(Legal guardian signature required if member is under the age of 19)