Dental $avings 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 # : _________________________________ E-mail: ____________________________________ Birthdate: __________________

Annual Membership Cost: $397

Additional Family Members to be Covered:

Additional Cost per Member:

Name: ____ Relationship: __________________ Birthdate: __________________ Add: ______

Name: ____ Relationship: __________________ Birthdate: __________________ Add: ______

Name: ____ Relationship: __________________ Birthdate: __________________ Add: ______

Name: ____ Relationship: __________________ Birthdate: __________________ Add: ______

***Total Amount Due:** _______________

*Annual Fee is required at enrollment and cannot be financed. Membership Fees for Dental Savings Plan are NON-REFUNDABLE. Failure to provide 48 hours notice when canceling or changing a dental hygiene appointment will VOID the benefit for that appointment. The missed appointment will count as one of your included professional cleanings. Harbor 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 Harbor Dental, prior to your 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 Harbor Dental and enclose check with application)

❑ Credit Card #: ____ Exp. Date: __________________________ CVC: __________________

❑ Set my account listed above to Auto Draft***

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

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

Please mail this completed application with appropriate payment (check or credit card information) to:

Harbor Dental | 202 Military East, Benicia, CA 94510

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: ____________________