



SCHILLING FARMS DENTAL

# Dental Savings 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: \$297**

### 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:** \_\_\_\_\_

### Payment Method:

Cash (in-office only\*\*)

\*\* If paying with cash, please return this application to our office in person. Do not mail cash payments.

Credit Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVC: \_\_\_\_\_

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

\*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. Schilling Farms 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 Schilling Farms Dental, prior to your anniversary renewal date.

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

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

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

**Schilling Farms Dental | 123 Crescent Dr Collierville, TN 38017**

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: \_\_\_\_\_