Smile Savings Membership Application

All fields are required.

Last Name	First Name		Middle Initial	Gender: M/F
Home Address	City	State	Zip	Phone Number
Employer				Are you utilizing this plan in lieu of dental insurance? Yes ▫ No ▫
Email Address				Date of Birth

Additional Members

Please list all eligible dependent(s) to be added to your policy.

First Name	Last Name	Date of Birth	Relationship to Applicant	Gender M/F

Plan Exclusions and Limitations

- This is a discount savings plan, not a dental insurance plan.
- Services may be restricted due to general health, physical or psychological limitations of patient.
- Not to be combined with any other dental plans, dental coverage, workers' comp claims, insurance claims, referrals to specialist or in conjunction with with other discounts or promotions.
- Plan must be paid in full at time of sign up. Non-refundable.

I have read and understand all terms, plan exclusions and limitations.
Your policy will become effective upon receipt of your annual premium.

Signed: ______________________________ Date: ____________________