AHDSmiles Dental Savings Plan
ENROLLMENT FORM

❑ 1st Time Enrollee ❑ Renewal	Preferred Location	Referred By

RESPONSIBLE PARTY / MEMBER INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.	First Name	(Nickname)	Middle	Last

Email Address	Birth Date (month/day/year) / /	Sex ❑ M ❑ F	Marital Status

Mailing Address	Unit	City	State	Zip Code

Mobile Phone Number ( )	Home Phone Number ( )	Work Phone Number ( )

Choose a Plan

❑ Individual Plan $84.00	❑ Partner Plan* $144.00	❑ Family Plan (3+)* $192.00

*Family plan includes up to 5 members. Each additional family member is eligible at $36 additional per year (equivalent to $3 per month)
*Partner & Family Plan include children enrolled full-time in college up to 24 yrs old or children not enrolled full-time in college up to 19 yrs old.

Additional Members	Relation	Birth Date (mm/dd/yy)	Sex
		/ /	❑ M ❑ F
		/ /	❑ M ❑ F
		/ /	❑ M ❑ F
		/ /	❑ M ❑ F
		/ /	❑ M ❑ F
		/ /	❑ M ❑ F

The AHDSmiles Dental Savings Plan is a dental savings plan, not a dental insurance plan and cannot be used in conjunction with another discount or insurance plan. Nor can it be combined with any other discount or offer. No refunds will be issued at any time if participant decides not to utilize dental plan. Dental Savings Plan Fee Schedule is subject to revision annually.

By signing this enrollment form, I agree to the terms of the AHDSmiles Dental Savings Plan that have been explained to me. I agree to pay the cost of my dental treatment in full at the time of service and I take full financial responsibility for the additional member(s) on this enrollment form.

_____ _____

Plan Holder Signature *Date*