DENTAL PASS APPLICATION
Effective Date:

Office:	**Sold By:**			**Plan Fee:**	
Last Name:	**First Name:**	**MI**		**Date of Birth:**	**Male / Female**
Address line 1:			**City:**		
Address line 2:			**State:**	**Zip Code:**	
Email Address:	**Home Phone:**			**Cell Phone:**	

***Payment Option*:**

12 months:

DEPENDENTS

Last Name	**First Name**	**MI**	**Birthday**	**Male / Female**
Last Name	**First Name**	**MI**	**Birthday**	**Male / Female**
Last Name	**First Name**	**MI**	**Birthday**	**Male / Female**
Last Name	**First Name**	**MI**	**Birthday**	**Male / Female**

☐ **AUTOMATIC RENEWAL**

I would like to automatically renew my Dental Pass when it is expiring. By checking this box, I am aware that in 12 months my credit card will be automatically charged. **If I do not inform the office to cancel my Dental Pass 15 days prior to this renewal date, the money will NOT be refunded once charged.**

Name on Card: ________________________

Credit Card Type (Circle): VISA MC DISCOVER AMEX

Credit Card #: _________________________

Expiration Date:__________ Security Code : _____

Renewal Amount:______________________

Dental Pass Contract and Terms of Agreement

Members may choose from the following payment options to retain membership and take advantage of Dental Pass services:

- ☐ Full-Year Membership terms: By paying the year in full, my coverage will be active for a full 12 months. At the end of the 12 months, membership will become inactive unless I pay for another 12 months or choose different payment option to continue. I can pay by cash, check or credit card. I understand and agree that this package is non-refundable.
  - Individual ---------$129.00
  - Two members-----$199.00
  - Three members---$249.00
  - Four members----$249.00

By checking the box above I hereby sign up for these terms of agreement as a Dental Pass Member and agree to pay the amount of agreed to and marked above.

X________________________________ Date:______________________