Dental $avings Plan Application Form

Primary Plan Holder:

First Name: ____________ Last Name: ____________ Middle Initial: ______ Social Security #: ____________

Address: ____________________ City: ____________ State: ______ Zip: ____________

Contact Phone # : ____________ E-Mail: ____________ Birthdate: ____________

Annual Membership Cost $299

Additional Family Members to be Covered:

Additional Cost Per Member:

Name: ____________ Relationship: ____________ Birthdate: ____________ Add: $276

Name: ____________ Relationship: ____________ Birthdate: ____________ Add: $177

Name: ____________ Relationship: ____________ Birthdate: ____________ Add: $165

Name: ____________ Relationship: ____________ Birthdate: ____________ Add: $110

*Total Amount Due: ____________

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental Savings Plan and Savings Plan Plus are NON-REFUNDABLE. The Masterpiece Smiles. reserves the right to modify, change, or discontinue the Dental Savings Plan, Savings Plan Plus, terms, fees, and services at the company's discretion upon written notice from The Masterpiece Smiles prior to your anniversary

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 The Masterpiece Smiles 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 The Masterpiece Smiles to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the Savings Plan Plus. The Masterpiece Smiles will notify me when the plan is renewed, for my records. If I choose to discontinue participating in the Savings Plan Plus, I will notify The Masterpiece Smiles one month prior to my anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card info) to our dental office location

18250 Roscoe Blvd. Suite 355 Northridge, CA 91325

By signing below, I acknowledge that I have read the Dental Savings Plan brochure and understand the plan details, benifits, and limitations.

Member Signature: ____________ Date: ____________