Savon Dental Plan®
America's Dental Plan

DOWNLOADABLE ENROLLMENT APPLICATION

(For more than 2 dependents use additional paper)

Please Enter The Number Of The Dental Center You Wish To Use:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Last 4 of Social Security #_____ Date of Birth:_____

Primary Members Email Address: _____@_____

Spouses Name:_____ Date of Birth:_____ Last 4 of Social Security #_____

Dependent Name:_____ Date of Birth:_____ Last 4 of Social Security #_____

Dependent Name:_____ Date of Birth:_____ Last 4 of Social Security #_____

Please accept my application for membership into the SAVON DENTAL PLAN®. I understand that my coverage begins immediately upon Savon's receipt of this application and will continue for one (1) year from the date the application is received except for Student or Transitional Plans. Once accepted by the company this contract is non cancelable and non-refundable. Savon Dental Plan makes no guarantees written or implied except as stated herein. All fees are considered earned by Savon upon receipt of this application.
At this time Savon Dental Plan is not available for purchase in the State of Florida.

PLEASE TELL US WHAT PLAN YOU ARE JOINING AND WHAT SIZE OF A PLAN YOU WANT

[ ] REGULAR PLAN*	[ ] SENIOR PLAN**	[ ] OTHER PLAN
[ ] SINGLE.....$144	[ ] SINGLE.....$109	PLAN NAME _____
[ ] DOUBLE....$184	[ ] DOUBLE....$134	SIZE_____
[ ] FAMILY.....$224		COST $_____

*Regular plan includes a one time $20.00 processing fee
**Senior plan includes a one time $25.00 processing fee

Savon Dental Plan® Benefits are not insurance
The plan only provides discounted dental benefits from participating providers within the plan.
Member is responsible for payment of the Savon fee at the time service is provided.
Savon® does NOT make any payments directly to the providers.

FOR CREDIT CARD PURCHASES ONLY
[ ] VISA [ ] MASTERCARD [ ] DISCOVER [ ] AMEX

Credit Card #_____ - _____ - _____ - _____

Expires on _____/_____ (MM/YY) CVC Code: _____

The CVC code: AMEX card is 4 digits on the front all others 3 digits are on the back

MAKE CHECK OR MONEY ORDER PAYABLE TO:
SAVON DENTAL PLAN
PO BOX
SHOW LOW, AZ 85902

Amount Enclosed With Application: $_____ Date: __/__/____

X _____ ***SIGN HERE... APPLICATION MUST BE SIGNED***

Contact Information: Phone: 602-841-3494 • Email: CustomerService@SavonDentalPlan.com