



Savon Dental Plan Downloadable Enrollment Application

(For more than 2 dependents use additional paper)

Please enter the name of the Dental Center you wish to use: _____

Last Name: _____ First Name: _____ MI: _____

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

Contact Phone: (____) _____ - _____ Last 4 of your Social Security #: _____ Date of Birth: ____/____/____

Primary members email address: _____@_____

Spouse 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 Savon Dental Plan. I understand that my coverage begins immediately upon Savon’s receipt of this application. By my signature on this application, I acknowledge that I understand that this is a contract and except for Transitional plans, is valid for one (1) year from the date this application is received. 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.

PLEASE TELL US WHICH PLAN YOU ARE JOINING

REGULAR PLAN SENIOR PLAN OTHER PLAN NAME _____

SINGLE \$ 134.00 SINGLE \$ 99.00 _____

DOUBLE \$ 174.00 DOUBLE \$ 124.00 SIZE: _____

FAMILY \$ 214.00 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 provides discounted dental benefits from providers in the plan network. Member is responsible for payment of the Savon fee at the time service is provided. Savon does NOT make any payments directly or indirectly to the providers.

For Payment By Credit Card



Credit Card # _____ - _____ - _____

Expires on (mm/yy): ____/____/____ CVC Code: _____ Amount \$: _____
(3 or 4 digits)

Amount Enclosed \$ _____ Date: ____/____/____

Please Sign Here X _____

Application Must Be Signed

Please make check or money order payable to
Savon Dental Plan
PO Box 54277— Phoenix, AZ 85078-4277