

# 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

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> REGULAR PLAN*    | <input type="checkbox"/> SENIOR PLAN**    | <input type="checkbox"/> OTHER PLAN |
| <input type="checkbox"/> SINGLE.....\$129 | <input type="checkbox"/> SINGLE.....\$ 94 | PLAN NAME _____                     |
| <input type="checkbox"/> DOUBLE...\$169   | <input type="checkbox"/> DOUBLE...\$119   | SIZE _____                          |
| <input type="checkbox"/> FAMILY.....\$209 |   | 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 \_\_\_\_\_ CVC Code: \_\_\_\_\_

Signature \_\_\_\_\_

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

Amount Enclosed With Application: \$ \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_

FOR OFFICE USE ONLY

X

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

MAKE CHECK OR MONEY ORDER PAYABLE TO:  
SAVON DENTAL PLAN  
PO BOX 54277  
PHOENIX, AZ 85078-4277

Revised 12/03/2018  
Downloadable Web App.