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 $ 129.00	[ ] SINGLE $ 94.00	_____
[ ] DOUBLE $ 169.00	[ ] DOUBLE $ 119.00	SIZE;_____
[ ] FAMILY $ 209.00		COST $_____

REGULAR PLAN INCLUDES A ONE TIME $20.00 PROCESSING FEE
SENIOR PLAN INCLUDES A ONE TIME $25.00 PROCESSING FEE

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

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 VISA MasterCard DISCOVER BANK

Credit Card # _____-_____-_____-_____

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

Amount Enclosed $_____ **Date:**_____/_____/_____

Please Sign Here X_____

Application Must Be Signed