Elite Dental Savings Plan Application

Print clearly in black ink and answer all questions or indicate "not applicable".

Your Profile:			
Name:		SSN:	
Address:			
City:	County:	State:	Zip:
Home Phone Number:		Work Phone Number:	
E-mail Address:			

Your Spouse Profile:			
Name:		SSN:	
Address:			
City:	County:	State:	Zip:
Home Phone Number:		Work Phone Number:	
E-mail Address:			

Your Children:		
Name:	Age:	SSN:
Name:	Age:	SSN:
Name:	Age:	SSN:
Name:	Age:	SSN:
Name:	Age:	SSN:

_____ _____

Member Signature Date

Plan	Total Annual Cost	Monthly Cost
Single Member	$250.00	$25.00
Each Additional Member	$200.00	$20.00
Example: Family with 4 Members	*$850.00*	*$85.00*

Payment Method:

1. **Check**: *One Time Payment*
   (Make checks payable to Elite Dentistry)
2. **Credit Card**: *Monthly Payments*

Credit Card Number:	Exp Date:
Signature:	VISA MC DISC AMEX
Your card will be charged on the first business day of the month. There will be a $10 fee for insufficient funds.	

Please mail this completed application with appropriate payment included to:

Elite Dentistry
100 Chelsea Corners Way Suite 113
Chelsea, AL 35043