Sullivan Dentistry Savings Plan Application Form

Effective Date: _____

Last Name: _____ First: _____ MI: _____

Home Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Additional covered plan members:

Name	Birth Date	Relationship	Name of School if full time student

Dental Health Care Associates Plan – Total Amount Due: _____

Payment Method:

- Check
- Cash
- Card # _____ Exp Date: _____ CVC: _____

By signing below, I acknowledge that I have read the brochure and understand the plan details and limitations.

Signature: _____ Date: _____
(Signature of plan holder)

*Annual fee is required at enrollment and cannot be financed. DHCA reserves the right to modify, change, or discontinue the DHCA Dental Plan, fees, terms, and services at the company's option upon written notice from DHCA prior to your anniversary renewal date.