Dental $avings Plan Application Form

Primary Plan Holder:

Effective Date: _____
FOR OFFICE USE ONLY

First Name: _____ Last Name: _____ Middle Initial: _____ Social Security # _____

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

Contact Phone #: _____ Email: _____ Bithdate: _____

Annual Membership Cost: $299

Additional Family Members to be Covered:

Additional Cost per Member:

Name: _____ Relationship: _____ Birthdate: _____ Add: **$276**

Name: _____ Relationship: _____ Birthdate: _____ Add: **$177**

Name: _____ Relationship: _____ Birthdate: _____ Add: **$165**

Name: _____ Relationship: _____ Birthdate: _____ Add: **$110**

***Total Amount Due:** _____

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental Savings Plan and Savings Plan Plus are NON-REFUNDABLE. Robert C. Scheele, DDS and Associates reserves the right to modify, change, or discontinue the Dental Savings Plan, Savings Plan Plus, terms, fees, and services at the company's discretion upon written notice from Robert C. Scheele, DDS and Associates prior to your anniversary renewal date.

Payment Method:

☐ Cash (in-office only**)

**If paying with cash, please return this application to our office in person. Do not mail cash payments.

☐ Check (make checks payable to Robert C. Scheele, DDS and Associates and enclose check with application)

☐ Credit Card #: _____ Exp. Date: _____ CVC: _____

☐ Set my account listed above to Auto Draft***

Auto-Renewal Program: Sign up now and save 5% off next year's premium!

***I, _____, autorize Robert C. Scheele, DDS and Associates to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Robert C. Scheele, DDS and Associates will notify me when the plan is renewed, for my records. If I choose to discontinue participating in the dental savings plan, I will notify Robert C. Scheele, DDS and Associates one month prior to my anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card info) to our dental office location:

Robert C. Scheele, DDS and Associates - 9830 Aubum Road, Suite 103, Fort Wayne, IN 46825

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

Member Signature: _____ Date: _____