Hewlett Family Dental
Dental Membership Plan Application

☐ Single $315
☐ Couple $565
☐ Family (up to 4) $695
#_____Additional Family Members at $150 each

Subscriber Information

Last Name: _____First Name_____ MI__

DOB ____/_____/_____ Gender: M / F SSN (Last 4 Digits) _____

Address / PO Box _____

City_____ State _____ Zip_____

Primary Contact phone number _____ Email_____

Covered Family Members:

Name _____DOB_____/_____/_____ Gender M /F
Name _____DOB_____/_____/_____ Gender M /F
Name _____DOB_____/_____/_____ Gender M /F
Name _____DOB_____/_____/_____ Gender M /F
Name _____DOB_____/_____/_____ Gender M /F

Total Due_____

☐Cash
☐Check # _____
☐Credit Card # _____Expiration date ___/___ CVV_____Type_____
Zip Code _____
Cardholder name _____Cardholder Signature_____

I understand the discounts and services provided with this plan, acknowledge all information is correct and payment for services is due the day of treatment. I understand that by signing this form I give authorization to charge my credit card for the above referenced enrollment fee.

Subscriber's Signature_____Date _____