

Hewlett Family Dental Dental Membership Plan Application

Single \$395

Couple \$645

Family (up to 4) \$895

_____ 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

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 _____