



Dental Savings Plan Application

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

E-mail: _____

Spouse, family members or employees to be included in coverage:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Employers:
To inquire about the
Dental Savings Plans,
visit our website:
www.smilecenterus.com
or contact the nearest
The Smile Center.

Please indicate the plan you have chosen below:

_____ **Green Plan:** One-year dental package with **15% discount** on services (\$200)

_____ **Gold Plan:** Green package plus \$500 credit and **20% discount** on services (\$700)

_____ **Platinum Plan:** Green package plus \$1000 credit and **25% discount** on services (\$1,200)

Method of Payment:

_____ **Check (Please make checks payable to "The Smile Center")**

_____ **Visa** _____ **Master Card** _____ **American Express** _____ **Discover**

Credit Card # _____ **Expiration Date:** _____

The Smile Center Dental Savings Plan:

I hereby apply for membership in this dental savings plan for myself and others named on this application form. I agree, for myself, and any others listed, to abide by the rules and regulations of the plan. I understand that all discount rates apply only to payments made in full at the time of service. I further understand that my coverage and benefits may be affected by my failure to provide complete and accurate information. I will promptly advise The Smile Center of any changes in this information.

Signature

Date

Bring, mail or fax this form to your nearest The Smile Center. (Fax numbers are listed below.)

Deerwood: :
(218)534-3949

Savage: :
(952)440-2935

St.Paul: :
(651)735-0521