ENROLLMENT APPLICATION

(For more than 2 dependents use additional paper)

Please Enter The Number Of The Dental Center You Wish To Use:______________

Last Name:____ First Name:____ MI:______________

Address:____ City:__________________________ State:_______________ Zip Code:_________

Home Phone:___________________ Work Phone:___________________ Last 4 of Social Security #_________________ Date of Birth:____________

Primary Members Email Address: ____@____________________

Spouses Name:___________________________________ Date of Birth:________________ Last 4 of Social Security #_________________

Dependent Name:_________________________________ Date of Birth:________________ Last 4 of Social Security #_________________

Dependent Name:_________________________________ Date of Birth:________________ Last 4 of Social Security #_________________

Please accept my application for membership into the SAVON DENTAL PLAN®. I understand that my coverage begins immediately upon Savon's receipt of this application and will continue for one (1) year from the date the application is received except for Student or Transitional Plans. Once accepted by the company this contract is non cancelable and non-refundable. Savon Dental Plan makes no guarantees written or implied except as stated herein. All fees are considered earned by Savon upon receipt of this application. ***At this time Savon Dental Plan is not available for purchase in the State of Florida.***

PLEASE TELL US WHAT PLAN YOU ARE JOINING AND WHAT SIZE OF A PLAN YOU WANT

[ ] REGULAR PLAN*	[ ] SENIOR PLAN**	[ ] OTHER PLAN
[ ] SINGLE.....$119	[ ] SINGLE.....$ 84	PLAN NAME ______________
[ ] DOUBLE...$159	[ ] DOUBLE...$109	SIZE____________
[ ] FAMILY......$199		COST $_________

*Regular plan includes a one time $20.00 processing fee

**Senior plan includes a one time $25.00 processing fee

Savon Dental Plan® Benefits are not insurance

The plan only provides discounted dental benefits from participating providers within the plan.
Member is responsible for payment of the Savon fee at the time service is provided.
Savon® does NOT make any payments directly to the providers.

FOR CREDIT CARD PURCHASES ONLY

[ ] VISA [ ] MASTERCARD [ ] DISCOVER [ ] AMEX

Credit Card #____

Expires on ___________________________ CVC Code: ______________
MM/YY

Signature ____

The CVC code: AMEX card is 4 digits on the front all others 3 digits are on the back

Amount Enclosed With Application: $ ____________________________

Date: __/__/____

X ***SIGN HERE... APPLICATION MUST BE SIGNED***

MAKE CHECK OR MONEY ORDER PAYABLE TO:
SAVON DENTAL PLAN
PO BOX 54277
PHOENIX, AZ 85078-4277

FOR OFFICE USE ONLY

Revised 01/30/2017
Downloadable Web App.