Print Form

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Savon Dental Plan

A division of Savon Professional Services Inc.
CustomerService@SavonDentalPlan.com
PO Box 54277 - Phoenix, AZ 85078
602-841-3494 or 800-809-3494 Fax 602-589-0417

Credit Card Monthly Recurring Payment Authorization Form

Important! Your plan will not become effective until this form is completed, signed and received by Savon Dental Plan.

You have requested Savon Dental Plan to schedule your payments to be automatically charged to your credit card. Please check over the information on this form, sign it and return it to us by fax at 602-589-0417 or in the self-addressed, stamped envelope as soon as possible. Your plan will become effective as soon as this form is received by Savon Dental Plan.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided prior to each charge. You also agree that this is a one (1) year commitment and will automatically renew unless you notify us in writing 15 days prior to your renewal date. After the first year, you may stop the drafts at anytime by phone, email or letter.

Please verify the information below:

I _____ authorize Savon Dental Plan to charge my credit card
(full name)

indicated below, the amount of $_____ on the _____ day of each Month for my monthly dental plan membership.

I understand that I will not receive advance notice of the charge, but will receive an email receipt.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Member Identification Number: _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name: _____

Card Number Ending with: xxxx-xxxx-xxxx-_____(Please use the same card # that you purchased the plan with)

Expiration Date _____ (Credit card must not expire for at least one (1) year from the date of the application)

This is an extension of credit to you by Savon Dental Plan and is a one year contract for monthly payments.

SIGNATURE _____ DATE _____

With my signature above, I authorize Savon Professional Services Inc., Savon Dental Plan to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I understand that my initial commitment is for one (1) year and I agree that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. I further understand that if I fail to complete the 1 year contract my dental facility will be notified and I will become liable for full payment for all procedures performed under this membership agreement and an early termination fee of $50.00 may be charged to my credit card.