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Kori & Everhart
Advanced Dentistry

Dental Savings Plan Application Form

Effective Date: _____
(office use only)

Primary Plan Holder:

First Name _____ Last Name _____ Middle Initial _____ Social Secuity ___-___-____

Address _____ City_____ State _____ Zip Code _____

Contact Phone Number _____-_____-_____ Email _____ DOB _____

Additional Family Members to be Covered:

Annual Membership Cost: $299

Name _____ Relationship _____ DOB _____ **Add $276**

Name _____ Relationship _____ DOB _____ **Add $177**

Name _____ Relationship _____ DOB _____ **Add $165**

Name _____ Relationship _____ DOB _____ **Add $110**

***Total Amount Due: $**_____

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental Savings Plan are NON-REFUNDABLE. Kori and Everhart Advanced Dentistry reserves the right to modify, change, or discontinue the Dental Savings Plan, terms, fees, and services at the company's discretion upon written notice from Kori and Everhart Advanced Dentistry prior to your anniversary renewal date.

Payment Method:

- ☐ Cash (cash accepted in office only, please do not mail)
- ☐ Check
- ☐ Credit Card #:_____Exp. Date: _____ /_____ CVC: _____
- ☐ Set my account listed above to Auto Renewal Program

Auto Renewal Program: Sign up now and save 5% on next year's premium!

I, _____, authorize Kori and Everhart Adanced Dentistry to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the Dental Savings Plan. Kori and Everhart Advanced Dentistry will notify me when the plan is renewed, for my records. If I choose to discontinue participating in the Dental Savings Plan, I will notify Kori and Everhart one month prior to my anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card info) to your preferred dental office location:

3420 Atrium Blvd. Suite 100, Franklin, OH 45005 OR 401 Miamisburg-Centerville Rd., Centerville, OH 45459

By signing below, I ackowledge that I have read the Dental Savings Plan brochure and understand the plan details, benefits, and limitations.

Member Signature:_____ **Date:**_____