APPLE DENTAL ENROLLMENT FORM

Name ☐ Non Member (Payer)

Representative's Name: _____
Representative's Phone #: _____

Office Use Only
Effective Date: _____
Application Number: _____

Last First (M) Date of Birth

Address Home Phone

City State Zip Business Phone

Employed By Alternate Phone

E-Mail

Additional Members **Relationship**

_____ (_____) / / Date of Birth

_____ (_____) / / Date of Birth

_____ (_____) / / Date of Birth

_____ (_____) / / Date of Birth

APPLICATION - AUTHORIZATION

I wish to become a member of APPLE DENTAL and understand my membership is on an annual basis and that I can terminate it on any anniversary date of my initial enrollment. It is my understanding I have the option of paying for membership on an annual or monthly basis. The latter will include two monthly payments plus $30 enrollment fee. (FIRST YEAR ONLY.) For monthly membership payment, I authorize the company to initiate debit entries to my (our) checking account or credit card. I understand it is the responsibility of APPLE DENTAL and myself to keep my membership in force. To guarantee uninterrupted service I approve of the Company's automatic monthly renewal of my membership upon expiration. This authority shall remain in effect until revoked by me in writing. I reserve the right to pay for membership on an annual basis if I desire. By accepting the plan, I am accepting the terms of this application and permission to be called by the company's computers..

Payment Options

☐ I would like to pay the entire annual premium plus the first year enrollment fee with my application.
☐ I would like to have my credit card or checking account debited monthly. (DO NOT CHECK BOX IF PAYING ANNUALLY)
It is my choice to make first year monthly payments on the 1th of each month.

Payment Schedule **2 Months Free**

Please check desired plan

Plan	Initial Payment* (First 2 months)	Monthly Cost	Annual Payment*
☐ Individual	$25.90	$12.95	$129.50
☐ Family Plan (everyone in the household)	$29.90	$14.95	$149.50

***PLUS one time first year enrollment fee: $30.00**

Your Credit Card Statement will read: **DDSI-APPLE DENTAL**

☐ AMERICAN EXPRESS ☐ DISCOVER ☐ MASTERCARD ☐ VISA

NAME ON ACCOUNT _____

CREDIT CARD NO. _____

EXPIRATION DATE _____

CUSTOMER CODE _____

Office use Only

Credit Card Authorization Number

Please allow 20-30 days to receive Permanent Membership Card(s).

******* *Pay to the order of* ***DDSI-APPLE DENTAL*** *****

Include **Initial Monthly Payment** or **Annual Payment**

PLUS $30.00 ENROLLMENT FEE

Signature X _____

All applications must be signed

APPLE DENTAL confirms that its Health Care providers are professional, but does not guarantee the quality of their services or products. Quality of care complaints concerning any APPLE DENTAL provider should be addressed to the appropriate licensing agency in your state.

Revised 10/09/2013