IVERSON
DENTAL CARE

Dental Savings Plan Agreement

Primary Plan Holder:

Name: ____

Annual Membership Cost: $295.00

Additional Family Members:

Name: ____ Amount Due: ____________

Name: ____ Amount Due: ____________

Name: ____ Amount Due: ____________

Total Due: ________________

Savings Plan will run from ________________________ to ________________________.

Payment Method:

- ❑ Cash
- ❑ Check
- ❑ Credit Card

Card Number: ______________________________________ Exp. Date: ___/___ CVC: ________

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

Signature: ____ Date:_____________________