SMART MOUTH DENTAL SAVINGS PLAN
APPLICATION

Effective Date:____/____/________-____/____/________ **Account Number:**______________________

Last Name:______________________________ **First Name:**________________________________ **MI:**________

Home Address: ____ **Date of Birth:**_________________

City: ____ **State:**_____________________ **Zip:**_________________

Covered Plan Members:

Name	Birth Date	Relationship	Cost per member
		(A) Member	
		(B)	
		(C)	
		(D)	
		TOTAL COST:	

Annual Membership Fee	
Individual	$97
Each Additional Family Member	$77

Payment Method

- ☐ Cash
- ☐ Check
- ☐ Debit/Credit Card # ____ **Expiration Date** __________**CVC** _______

By signing below, I acknowledge that I have read the brochure and understand the plan details and limitations.

Signature:____ **Date:**______________________
(signature of plan holder)

SMART MOUTH DENTAL SAVINGS PLAN CREDIT CARD AUTO-RENEWAL

Yearly Renewal-Your credit card will be charged one year from your enrollment date to ensure your continued coverage. A 30-day advance written notice is required to opt-out of automatic renewal. If you choose the auto-renew option, credit card or checking account information will be necessary for membership and auto-renewal fee.

Membership is effective the date in which payment is received and terminates the last day of that month the following year.

I authorize Legacy Smiles to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the Smart Mouth Dental Savings Plan. If I choose to discontinue participating in the advantage plan at the end of my annual membership, I will notify Legacy Smiles one month prior to my anniversary renewal date.

Signature:____ **Date:**________________
(signature of plan holder)

Debit/Credit Card # ____ **Expiration Date**____________ **CVC**_________

Checking Account # ____ **Routing #** ____

*Annual fee is required at enrollment. Membership may be canceled within 30 days of purchase for a refund. Enrollment costs and administration fees are not refundable. If membership is canceled or refunded, all discounted services are void from the date of purchase, Legacy Smiles reserves the right to modify, change, or discontinue Smart Mouth Dental Savings Plan fees, terms, and services at the company's option prior to your anniversary renewal date. For more information please visit our website at **www.Legacy-Smiles.com**

For Office Use Only:

Name of employee processing application:____

Expiration date of membership: Month: ____________ Day:____________ Year: ______________

Notes: ____