



**Dr. Wade Larson • Dr. Brendan Green**

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## CHOICE DENTAL PLAN ENROLLMENT FORM

**ADULT MEMBER INFORMATION:** (18 years of age and older)

First Name: _____	Last Name: _____	MI: _____
Address: _____	Apt #: _____	
City: _____	State: _____	Zip Code: _____
Home Phn: _____	Work Phn: _____	Cell Phn: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birthdate: ____/____/____	SSN: ____-____-____	Marital Status: _____
Spouse/Partner		
First Name: _____	Last Name: _____	MI: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birthdate: ____/____/____	SSN: ____-____-____	

**CHILD AND/OR ADDITIONAL FAMILY MEMBER INFORMATION:** (please print clearly)

Name: _____	Date of Birth: ____/____/____
Name: _____	Date of Birth: ____/____/____
Name: _____	Date of Birth: ____/____/____
Name: _____	Date of Birth: ____/____/____

**ANNUAL PREMIUM:**

Member/Spouse Cost:	\$ 275.00	x _____	=	_____
Child and/or additional family member Cost:	\$ 235.00	x _____	=	_____
		Total	=	_____

**METHOD OF PAYMENT:**

<input type="checkbox"/> CASH	<input type="checkbox"/> VISA <input type="checkbox"/> MC <input type="checkbox"/> AMEX <input type="checkbox"/> DISCOVER
<input type="checkbox"/> CHECK # _____	<input type="checkbox"/> CareCredit

I have read and understand the information given to me regarding the dental benefits in the Choice Dental Plan at Ben Lomond Dental.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Enrollment Date