Enrollment Form

Last Name:_____ First_____ MI _____

Home Address:_____

City: _____ State _____ Zip _____

Best phone number to contact: _____

Birthdate ___/___/____ Employer _____

List Covered Dependents

Name	Birthdate	Relationship

Payment Method:

Annual Payment:

____Check Enclosed: $_____ (make checks payable to Concord Smile)

____ Card # _____

Expiration Date: ____/____

Card Type: Visa/Mastercard (circle one)

Signature: _____

Please read and sign below:

I understand the benefits, limitations, exclusions and requirements of the Concord Smile Dental Plan and I agree to the following:

1. I will remain in the plan and pay membership fees for a minimum of 12 months.
2. Payment of less than 12 months membership fees may cause me to be charged the usual and customary fees for all services (including those already provided) and my being charged for the remaining months fees in lump sum.
3. Fees for dental services are due when services are rendered
4. Fees for prosthodontics and cast restorations are due at the at the preparation/impression visit. Failure to comply may result in my being charged usual and customary fees for such services
5. I agree to pay any and all cost in collecting and charges, including but not limited to attorney fees and court costs

Signature: _____ Date: _____

Mail this form to:

Concord Smile

2933 Salvio St

Concord, CA 94519