Enrollement 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