Discount Dental Plan Application

☐ New ☐ Renewal Effective Date: _____ Practice Location: _____

Member:

Name: DOB: Sex: M F

SSN (last four digits): Email:

Address: P.O Box:

City: State: Zip:

Home phone: Work phone: Cell phone:

Additional Members:

Name: Relationship: DOB: Sex: M F SSN (last four digits):

Name: Relationship: DOB: Sex: M F SSN (last four digits):

Name: Relationship: DOB: Sex: M F SSN (last four digits):

Name: Relationship: DOB: Sex: M F SSN(last four digits):

Name: Relationship: DOB: Sex: M F SSN (last four digits):

Name: Relationship: DOB: Sex: M F SSN (last four digits):

MEMBER SIGNATURE: Date:

Coverage Type: (select one)

☐ Single $227.00 for 1 Adult or 1 Child ☐ Dual $439.00 for Parent/Child or husband/Wife

☐ Family $698.00 Includes children enrolled full-time in college until age 26, or children not enrolled full-time in college until age 18

Payment Type:

☐ Cash: Amount: _____ ☐ Check: Number: _____

☐ Credit Card # CVV: Exp Date: Card Type:_____

*****Authorized Signature: Date:**

Complete this form and mail along with your payment or credit card authorization to:

Howard Discount Dental Plan
1020 Bryan Woods Loop, Suite 6
Savannah, GA 31413

Questions: (888) 380 0399
Make checks payable to Howard Family Dental