TOTAL TRANSFORMATION
DENTAL AND SPA

# Dental Savings Plan Enrollment Form

**Please Check One:** **Enrollment Date**_____

☐ Single Premium Plan ☐ Dual Premium Plan ☐ Family Premium Plan

Please PRINT clearly and answer all questions or indicate "not applicable".

## Applicant Profile

Name_____

Social Security Number_____Date of Birth_____

Mailing Address_____

Home Phone Number_____Cell Phone Number_____

Work Phone Number_____Email Address_____

Driver's License/ ID Number_____State of Issue_____

## Spouse's Profile

Name_____

Social Security Number_____Date of Birth_____

Mailing Address_____

Home Phone Number_____Cell Phone Number_____

Work Phone Number_____Email Address_____

Driver's License/ ID Number_____State of Issue_____

## Your Children

Name_____Age_____Social Security Number_____
Name_____Age_____Social Security Number_____
Name_____Age_____Social Security Number_____
Name_____Age_____Social Security Number_____
Name_____Age_____Social Security Number_____
Name_____Age_____Social Security Number_____

**Applicant Signature**_____**Date**_____

**Payment Information Type:** Visa MC Check Care Credit Cash

**Credit Card Number**_____**Expiration Date**_____

**Billing Address**_____

**Authorized Signature**_____**Date**_____