TOTAL TRANSFORMATION
DENTAL AND SPA

Dental Savings Plan Enrollment Form

Enrollment Month_____

Please Check One:

☐ Adult ☐ Adult + ☐ Periodontal ☐ Child (under 14)

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

Member Information

Name_____

Social Security Number_____ Date of Birth_____

Mailing Address_____

Phone Number_____ Email Address_____

I have read and understand all the terms listed for the Dental Savings Plan. I understand that this is not a dental insurance plan, but a dental membership plan that is only valid for Total Transformation Dental and Spa. I understand that there will be a $95.00 reinstatement fee for lapse of coverage beyond the enrollment period.

Signature_____ **Today's Date**_____

AUTODRAFT – Spread your enrollment fee over 12 months

By signing below and providing payment information, I authorize Total Transformation Dental And Spa to charge the card listed below on the _____ day of each month for 11 consecutive months.
Failure of payment will result in termination of the Dental Savings Plan. A $95 re-instatement fee will be required to re-enroll. After 2 instances of auto-draft not going through, we reserve the right to require payment in full for DSP.

Payment Information Type_____
Credit Card Number_____
Expiration Date_____ **CVV Code**_____
Billing Address_____

Authorized Signature_____ **Today's Date**_____