

# MEMBERSHIP APPLICATION

NEW ENROLLMENT     RENEWAL

## PRIMARY MEMBER

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Mobile Number: \_\_\_\_\_ Sex:  M  F

Mailing Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Billing Address: \_\_\_\_\_ Other Contact Number: \_\_\_\_\_

## LIST OF COVERED DEPENDENTS:

Name:	Birthday	Relationship	Name:	Birthday	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## PLAN (One Year Membership Plan)

Basic Plan (\$359)                       Basic Plan (Additional Family Member) x: \_\_\_\_ (\$329)                      Total: \$ \_\_\_\_\_

Periodontal Plan (\$679)                       Periodontal Plan (Additional Family Member)x: \_\_\_\_ (\$649)                      Total: \$ \_\_\_\_\_

Grand Total: \$ \_\_\_\_\_

## PAYMENT INFORMATION

Cash                       Check                       Credit Card                       Care Credit

Card Number: \_\_\_\_\_ CVV: \_\_\_\_\_ Expiration: \_\_\_\_\_

Card Holder Name (if different from applicant): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship with card holder: \_\_\_\_\_ Card Holder Signature: \_\_\_\_\_

## TERMS AND LIMITATIONS OF THE PLAN

As a Mountain West Dental Healthy Smiles Plan Member, I hereby agree and understand the following:

1. Payment is due at the time services are received.
2. Mountain West Dental Healthy Smiles Plan is not an insurance policy and cannot be combined with any other dental/health insurance.
3. If referred to a specialist, they will NOT honor this discount
4. This plan is non-transferrable (family members cannot be substituted in for another family member).
5. The membership fee is non-refundable if you choose not to use the plan.
6. Rates are subject to change at any time.

The plan will **NOT** automatically renew after one year. Member will be responsible for renewal each year.

Primary Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FOR OFFICE USE ONLY

Enrolled By: \_\_\_\_\_ Date: \_\_\_\_\_

Membership Start Date: \_\_\_\_\_

Membership Renewal Date: \_\_\_\_\_ Total Payment: \$ \_\_\_\_\_



**Mountain West Dental**  
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