Mountain West Dental Healthy Smiles Plan

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 Renwal Date: _____ Total Payment: $ _____

MOUNTAIN WEST Dental PC
Dr. Aaron Erickson

Mountain West Dental
207 Richards Ave.
Gillette, WY 82716