

## Savings Plan Application

Effective Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Check One:

**Traditional Plan \$289**

**Perio Maintenance Plan \$545**

### Payment Method

Check

Cash

Debit/Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVC: \_\_\_\_\_

Care Credit

*\*\*Annual fee is required at the time of enrollment and is non-refundable. The office of Robert W. Koubsky, D.D.S. reserves the right to modify, change, or discontinue the Savings Plan fees, terms, and services at the company's discretion upon written notice from the office of Robert W. Koubsky, D.D.S. prior to your anniversary renewal date\*\**

***By signing below, I acknowledge I have read the Koubsky Dental Savings Plan information provided to me and understand the plan details and limitations***

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

(parent signature required if member is under the age of 18)