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)