ROSEMAN UNIVERSITY DENTAL MEMBERSHIP PLAN APPLICATION

PERSONAL INFORMATION			
Name:		Date of Birth (MM/DD/YY):	
Address:			
City:		State:	ZIP Code:
Home Phone:	Cell:	Work:	
E-mail:			

SPOUSE'S INFORMATION			
Name:		Date of Birth (MM/DD/YY) :	
Address:			
City:		State:	ZIP Code:
Home Phone:	Cell:	Work:	
E-mail:			

ADDITIONAL FAMILY MEMBERS		
Name:	Gender: M ☐ F☐	Date of Birth (MM/DD/YY):
Name:	Gender: M ☐F☐	Date of Birth (MM/DD/YY):
Name:	Gender: M☐ F☐	Date of Birth (MM/DD/YY) :
Name:	Gender: M ☐F☐	Date of Birth (MM/DD/YY):
Name:	Gender: M ☐F☐	Date of Birth (MM/DD/YY) :

PLAN SELECTIONS			
Individual (First Member):	☐$12.00/month or $144.00/year	Annual Cost: $144.00	Paid: $_____
Second Family Member	☐ $7.00/month or $86.00/year	_____	_____
Additional Family Member(s)	☐ $5.00/month or $60.00/year X _____	_____	_____
		Total Annual Cost $ _____	Total Paid: $_____

PAYMENT METHOD			
Check: #_____ Amount: _____			
Credit Card: Master Card ☐	VISA ☐	Discover ☐	American Express ☐
Card Holder Name:			
Card Number:	Exp Date:	CVR Code:	Zip Code:
Card Holder Signature:			

AGREEMENT

1. You may pay you membership dues either for the full year or monthly. If monthly payments are chosen, first and second month's dues are to be paid at sign up.
2. Purchaser of this dental membership program may cancel this contract with or without cause within 30 days of signing this contract by submitting a written notice of cancellation to Roseman University. If during the first 30 days you cancel your membership plan, all dues paid in relation to this dental membership program shall be refunded.
3. You may not use the right of cancellation if you and or family members has used the services of the dental membership plan.
4. I have read and agree to the full contract included with this application.
5. Dues are subject to change annually.

SIGNATURE OF ACCEPTANCE

Member Signature: _____ Date: _____

Print Name: _____