

SMILE SAVERS ENROLLMENT APPLICATION

MEMBER INFORMATION:

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Telephone #: _____ Social Security #: _____

Employer: _____ Center Selected: _____

(See Back for Locations)

Names of Dependents*:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

*Dependents shall mean children up to age 19 and full time students to age 23. All other members must pay the \$79.00 for their own account.

ANNUAL MEMBERSHIP FEE:

- Member: \$79.00
- Family (Up to 4 Members): \$149.00

METHOD OF PAYMENT:

- Payment enclosed (Make check or money order payable to Midwestern Dental.)
- Visa Discover
- MasterCard American Express

Card #: _____ Security Code (3 or 4 digit # on back of card): _____

Expiration date: _____ Billing zip code: _____

Name on card: _____

Signed: _____ Date signed: _____

SMILE SAVERS
c/o Midwestern Dental
5050 Schaefer Road
Dearborn, MI 48126