Beasley Affordable Dental Plan Enrollment

Primary Member Information		
Name:		SSN:
Address:		
City:	State:	Zip:
Home Phone Number:	Work Phone Number:	
Cell Phone Number:	E-mail Address:	
Employer:	Drivers License #:	

Spouse Information	
Name:	SSN:
Cell Phone Number:	Work Phone Number:
Employer:	E-mail Address:

Children Information		
Name:	Age:	SSN:
Name:	Age:	SSN:
Name:	Age:	SSN:
Name:	Age:	SSN:
Name:	Age:	SSN:

I agree that I have read and understand the plan exclusions, limitations, and guidelines. I understand that the plan has a minimum 12 month enrollment period and that failure to make the agreed monthly payments will forfeit plan discounts for dental treatment and result in action being taken against me to collect the full cost of any treatment provided. This plan will automatically renew at the end of 12 months unless cancelled.

Member Signature　　　　Date

Plan	Total Annual Cost	Monthly Cost
Single Member	$250.00	$25.00
Each Additional Member	$200.00	$20.00
Example: Family with 4 Members	*$850.00*	*$85.00*

Payment Method:

1. **Check**: *One Time Payment (best deal)*
   (Make checks payable to Beasley Dentistry)
2. **Credit / Debit Card**: *Monthly Payments*

Credit / Debit Card Number:	Exp Date:
Signature:	VISA MC DISC AMEX
Your card will be charged on the 1-10 business day of the month. There will be a $20 fee for insufficient funds.	

Mail this form with your payment to: Beasley Dentistry, 200 East Hobbs st, Athens, al 35611 or email to contactus@beasleydentistry.com