DR. RICHARD G. WYNE
family dentistry

Dental $avings Plan Application Form

Primary Plan holder:

Effective Date: _____
[For Office Use Only]

First Name: _____ Last Name: _____ Middle Initial: ___ SSN#: _____

Address: _____ City: _____ State: ___ Zip: _____

Contact Phone #: _____ Email: _____ Birth Date: _____

Annual Membership Cost----$299

Additional Family Members to be Covered:

Additional Cost per Member:

Name: _____ Relationship: _____ DOB: _____ Add: **$285**

Name: _____ Relationship: _____ DOB: _____ Add: **$271**

Name: _____ Relationship: _____ DOB: _____ Add: **$265**

Name: _____ Relationship: _____ DOB: _____ Add: **$230**

***Total Amount Due: $_____**

*Annual fee is required and cannot be financed. Membership fees for Dental $avings Plan are NON-Refundable. Richard G. Wyne DDS, PA reserves the right to modify, change, or discontinue the Dental $avings Plan, terms, fees, and services at the company's discretion upon written notice from Richard G. Wyne, DDS, PA prior to your anniversary renewal date.

Payment Method:

☐ Cash [in office only**]

**If paying with cash, please return this application to our office in person. Do not mail cash payments.

☐ Check (make checks payable to Richard G. Wyne, DDS, PA and enclose check with application)

☐ Credit Card #: _____ Exp. Date: _____ CVC: _____

☐ **Set my account listed as Auto Draft*****

Auto-Renewal Program: Sign up now and save 5% off next year's premium!

***I, _____, authorize Richard G. Wyne, DDS, PA to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Richard G. Wyne, DDS, PA will notify me when the plan is renewed, for my records. If I choose to discontinue participating in the dental savings plan, I will notify Richard G. Wyne, DDS, PA one month prior to my anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card information) to:

4110 Aspen Hill Road, Suite 310, Rockville, MD 20853

By signing below, I acknowledge that I have read the Dental Savings Plan brochure and understand the plan details, benefits, and limitations.

Member Signature: _____ Date: _____