(847) 392-4422

Savings Plan Application

Your Profile		
Name:		SS#:
Address:		
City:	State:	Zip:
Phone: ( )	Alt Phone: ( )	
Email:		

Spouse		
Name:		SS#
Address:		
City	State:	Zip:
Phone: ( )	Alt Phone: ( )	
Email:		

Your Children		
Name:	DOB:____/____/_____	SS#
Name:	DOB:____/____/_____	SS#
Name:	DOB:____/____/_____	SS#
Name:	DOB:____/____/_____	SS#
Name:	DOB:____/____/_____	SS#

_______________________________ Member Signature

_______________ Date

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

1307 North Rand Rd
Arlington Heights, IL

Single:	$399.00
Double:	$773.00
Family (3):	$1147.00
Family (4):	$1496.00
Additional Members:	$199.00/each

Make checks payable to:
Associates for General Dentistry, Ltd.

Credit Card Number: _________________________ Expiration:___________ 3-Digit code________

Authorization Signature:__________________________________ Visa MasterCard Discover Amex

Annual Auto Renewal option: Yes / No