COLUMBIA DENTAL DESIGNS

General, Family & Cosmetic Dentistry

Dental $avings Plan Application Form

Primary Plan Holder:

Effective Date: _____
FOR OFFICE USE ONLY

First Name: _____ Last Name: _____ Middle Initial: _____ Social Security # _____

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

Contact Phone # : _____ E-mail: _____ Birthdate: _____

Annual Membership Cost: $347

Additional Family Members to be Covered:

Additional Cost per Member:

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

***Total Amount Due:** _____

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 Dr. Jay Yi and enclose check with application)

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

❑ Set my account listed above to Auto Draft***

*Annual Fee is required at enrollment and cannot be financed. Membership Fees for Dental Savings Plan are NON-REFUNDABLE. Failure to provide 48 hours notice when canceling or changing a dental hygiene appointment will VOID the benefit for that appointment. The missed appointment will count as one of your included professional cleanings. Columbia Dental Designs reserves the right to modify, change, or discontinue the Dental Savings Plan, terms, fees, and services at the company's discretion upon written notice from Columbia Dental Designs, prior to your anniversary renewal date.

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

I, _____, authorize Columbia Dental Designs to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Columbia Dental Designs 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 Columbia Dental Designs one month prior to my anniversary renewal date.

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

Columbia Dental Designs - 8600 Snowden River Pkwy, Ste 308. Columbia, MD 21045

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: _____