BRANCHVIEW
Dental Care
Beautiful Smiles, Endless Possibilities

Premier Dental Savings Plan
Enrollment Form

Date of Enrollment* _____
*Coverage date is one year from this date.

Family Members Names/Date of Birth Participating in the Plan

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I have read and agree to the benefits and guidelines as detailed in the brochure.

Guidelines:

- This plan cannot be combined with any other discounts.
- Reduced dental service fees are valid only after enrollment is paid.
- Must be paid in full at time of service. Any service NOT paid for at time of service will be billed at regular fees.
- If using Care Credit, the discount will be reduced for Care Credit fee.
- Cannot be used for any Specialists.
- Plan is in effect for one year and is non-refundable.

This is not an insurance product.

Patient Signature_____

Date _____