FAMILY DENTAL ASSOCIATES
328 MARGIE DR.
WARNER ROBINS, GA 31088
PHONE: 478 - 971-7701
FAX: 478-971-7705

J. ALEX BELL, JR., D.M.D. JACK ALEX BELL, III, D.M.D.
KEN COLSON D.M.D.

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 #: _____ Email: _____ Bithdate: _____

Additional Family Members to be Covered:

Name: _____ Relationship: _____ Birthdate: _____ Add:

Name: _____ Relationship: _____ Birthdate: _____ Add:

Name: _____ Relationship: _____ Birthdate: _____ Add:

Name: _____ Relationship: _____ Birthdate: _____ Add:

*Total Amount Due: _____

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental $avings Plan is NON-REFUNDABLE. Family Dental Associates reserves the right to modify, change, or discontinue the Dental $avings Plan, Savings Plan Plus, terms, fees, and services at the company's discretion upon written notice from Family Dental Associates 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 Family Dental Associates and enclose check with application)

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

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

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

***I, _____, autorize Family Dental Associates to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the Dental $avings Plan. Family Dental Associates 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 Family Dental Associates one month prior to my anniversary renewal date.

Please mail this completed application with appropriate payment (check or credit card info) to our dental office location:
Family Dental Associates - 328 Margie Drive Warner Robins, GA 31088

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

Member Signature: _____ Date: _____