

**PERSONAL SMILE PLAN
APPLICATION FORM**

PLEASE PRINT IN INK OR TYPE

Your First Name: _____

Your Last Name: _____

Your Address: _____

Date of Birth: _____

Social Security Number: _____

Your Phone Number: _____

Type of plan _____ Individual _____ Family _____ Senior Citizen

If Family Membership, Enter the information about each dependent below:

<u>Name</u>	<u>Date of Birth</u>	<u>Social Security Number</u>	<u>Relationship</u>
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I hereby enroll in the Personal Smile Plan discount dental plan offered by Javan Dental Inc. I have read and understand the conditions and exclusion of the program as described by the Membership Agreement. I understand that the discount program applied for shall become effective after signing of this enrollment form and payment of the first annual premium.

Signature: _____

Date: _____