Rifle Smiles Dental Savings Plan

Enrollment Application

Subscriber _____Date of Birth _____

Address_____

City_____State_____Zip _____

Telephone _____

Email_____

Employer _____Telephone _____

Additional Members

#2 Member Name _____Date of Birth _____

#3 Member Name _____Date of Birth _____

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1 Adult Member	$347.00
1 Couple (limitations apply)	$657.00
Child Members(5-15 years)	$297.00

Total Payment for Membership Fee (s) $_____.00

Payment Options: Check enclosed Bill my Visa or MasterCard

Credit Card#_____

Expiration Date_____ CVC _____

I understand and accept the terms and conditions of Rifle Dental Care Oral Health Savings Plan as summarized online and/or in the brochure. By this signature or electronic signature, I hereby authorize Rifle Dental Care to charge my Credit Card by Phone or in person for the payment of my One-Year Membership(s).

Subscriber Signature _____ Date _____

Fax: (970)616-3004 / Email: office@rifledentalcare.com/
Mail: Rifle Dental Care / 1430 Railroad Ave. Suite B / Rifle CO 81650