

Nelson Family Dental Benefit Plan Application *Applicant Information*

First Name: _____ M.I.: _____ Last Name: _____
Date of Birth: (mm/dd/yyyy) _____ SSN: _____ Email: _____
Current Address / City: _____ State: _____ Zip Code: _____
Mailing Address (if different than above):
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Preferred Contact #: H C W

Employment Information

Current Employer: _____
Employer Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____
Position: _____ Phone: _____

Family Member #1

First Name: _____ M.I.: _____ Last Name: _____
Date of Birth: (mm/dd/yyyy) _____ SSN: _____ Email: _____
Current Address / City: _____ State: _____ Zip Code: _____
Check One: Employed Self-Employed Retired Student Gender: M F Relation to Applicant: _____

Family Member #2

First Name: _____ M.I.: _____ Last Name: _____
Date of Birth: (mm/dd/yyyy) _____ SSN: _____ Email: _____
Current Address / City: _____ State: _____ Zip Code: _____
Check One: Employed Self-Employed Retired Student Gender: M F Relation to Applicant: _____

Family Member #3

First Name: _____ M.I.: _____ Last Name: _____
Date of Birth: (mm/dd/yyyy) _____ SSN: _____ Email: _____
Current Address / City: _____ State: _____ Zip Code: _____
Check One: Employed Self-Employed Retired Student Gender: M F Relation to Applicant: _____

Family Member #4

First Name: _____ M.I.: _____ Last Name: _____
Date of Birth: (mm/dd/yyyy) _____ SSN: _____ Email: _____
Current Address / City: _____ State: _____ Zip Code: _____
Check One: Employed Self-Employed Retired Student Gender: M F Relation to Applicant: _____

Acknowledgement:

- By submitting this form, I acknowledge that I am 18 years of age or older, or have permission from my parent/guardian to apply to this program
 By submitting this application, I acknowledge that I have read over the fees and payment requirements. I know and understand that should I enroll with Nelson Family Dental Group Benefit Plan, I will be responsible for paying my fees in full via an agreed upon payment method.

Nelson Family Dental Group Benefit Plan Application Notes:

- Members must pay the application fee and membership fee prior to receiving a membership card.
- Cannot be used for purchase of dental retail products.
- Total payment amount is due at time of service. If full payment is not received at time of service, fee reduction will be void.
- Cannot be combined with any other dental insurance or discount.
- Payment is due at the start of each membership year and is non-refundable.
- Courtesy fee reduction or included dental services are non-transferable.

Signatures:

I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application.

Signature of Applicant: _____ Date: _____