Savon Dental Plan®
PO Box 54277
Phoenix, Arizona 85078-4277
1-800-809-3494 – www.SavonDentalPlan.com
America's Dental Plan℠

Conversion Enrollment Application

Please print clearly. Black or blue ink only, please.

Please tell us which plan you are converting from and the name of your dentist:

Plan:_____

Old ID# :_____ Expiration Date: ___/____/____

Current Dentist:_____

Upon my renewal, I will be joining

(please check plan type and circle desired plan size)

[ ] Regular Plan

Single	Double	Family
$109	$149	$189

[ ] Senior Plan

Single	Double
$69	$94

(This section is for the PRIMARY on the account ONLY)

Name: _____
(Last) (First) (MI)

Address: _____ City: _____ State:____ Zip Code: _____

Home Phone: (____)_____ Last 4 digits of SSN: _____ Date of Birth: _____/_____/_____

Alternate Phone:(____)_____ Email: _____@_____

(use this section for additional members and dependents if applicable)

Spouse/Partner: _____ Birthday: _____/_____/_____ Last 4 digits of SSN: _____

Dependent: _____ Birthday: _____/_____/_____ Last 4 digits of SSN: _____

Dependent: _____ Birthday: _____/_____/_____ Last 4 digits of SSN: _____

(For more than two dependents use additional paper)

Please accept my application for membership into the SAVON DENTAL PLAN®. I understand that my coverage begins immediately upon Savon's receipt of this application and will continue until the expiration date of the plan I am converting from. Once accepted by the company, this contract is non-cancelable and non-refundable. Savon Dental Plan makes no guarantees, written or implied, except as stated herein. All fees are considered earned by Savon upon receipt of this application.

X_____ Date: _____/_____/_____

SIGN HERE! Application MUST be signed in order to be processed.

PLEASE NOTE: Identification card from old plan MUST accompany this application (primary member's only)

(DO NOT write below this line. This section is for OFFICE USE ONLY)

Dental Center Number: _____ Date application accepted: ____/____/_____ By: _____