Dr. Wade Larson ● Dr. Brendan Green
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(801) 782-0866 benlomonddental@gmail.com

CHOICE DENTAL PLAN
ENROLLMENT FORM

ADULT MEMBER INFORMATION: (18 years of age and older)

First Name: _____ Last Name: _____ MI: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phn: _____ Work Phn: _____ Cell Phn: _____
Sex: ☐ M ☐ F Birthdate: _____/_____/_____ SSN: _____-_____-_____ Marital Status: _____

Spouse/Partner
First Name: _____ Last Name: _____ MI: _____
Sex: ☐ M ☐ F Birthdate: _____/_____/_____ SSN: _____-_____-_____

CHILD AND/OR ADDITIONAL FAMILY MEMBER INFORMATION: (please print clearly)

Name: _____ Date of Birth: _____/_____/_____
Name: _____ Date of Birth: _____/_____/_____
Name: _____ Date of Birth: _____/_____/_____
Name: _____ Date of Birth: _____/_____/_____

ANNUAL PREMIUM:

Member/Spouse Cost:	$ 315.00	x	_____	=	_____
Child and/or additional family member Cost:	$ 275.00	x	_____	=	_____
			Total	=	_____

METHOD OF PAYMENT:

☐ CASH ☐ VISA ☐ MC ☐ AMEX ☐ DISCOVER
☐ CHECK # _____ ☐ CareCredit

I have read and understand the information given to me regarding the dental benefits in the Choice Dental Plan at Ben Lomond Dental.

_____ _____
Signature of Applicant Enrollment Date