



Application for In-House Dental Plan

Personal information:

Name _____ Email Address _____
Home Address _____ D.O.B _____
City _____ State _____ Zip _____
Home phone _____ Mobile _____ Work _____

Spouse's information:

Name _____ Email Address _____
Home Address _____ D.O.B _____
City _____ State _____ Zip _____
Home phone _____ Mobile _____ Work _____

Children's information:

Name _____	D.O.B _____	M / F _____
Name _____	D.O.B _____	M / F _____
Name _____	D.O.B _____	M / F _____
Name _____	D.O.B _____	M / F _____

Individual **\$345**

Each additional family member **\$245** X _____ = _____

Total (Annual Cost): _____

Applicant's signature _____ Date _____

Please make **check** payable to **McGann Family Dental**

Credit Card: AmEx Discover MC Visa

Card Number _____ Exp. Date _____

Cardholder's signature _____

Please mail or drop off completed application with corresponding payment to:

McGann Family Dental