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 **$375**

Each additional family member **$325** 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