



PO Box 54277
Phoenix, Arizona 85078-4277
1-800-809-3494 – www.SavonDentalPlan.com

America's Dental Plan SM

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

[] Senior Plan

Single Double Family
\$99 \$139 \$179

Single Double
\$59 \$84

(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: _____