



YOUNG DENTAL CARE
YOUNG B. PARK, D.D.S.

Smart Savings Plan Application

All fields are required.

Last Name	First Name	Middle Initial	Gender: M/F
Home Address	City	State	Zip
Employer			Phone No. (Mobile)
Employer			Work No.
E-mail Address			Date of Birth
By providing my email address, I agree to receive communications regarding my dental care via e-mail. I may revoke this authorization at any time by contacting Young Dental Care.			

Reason for Application : New Enrollment Change of Dependent(s)

Plan Chosen: 1 Year 2 Years

Automatic Renewal: Yes No

Please list all eligible dependent(s) to be covered under this policy.
Proof of eligibility coverage is not required upon application, but may be requested periodically.

First Name	Last Name	Date of Birth	Relationship to Applicant (Spouse, Domestic Partner, or Dependent Child)	Gender M/F

Plan Exclusions and Limitations

- Demonstration of non-compliance with recommended course of treatment
- Services which in the opinion of the attending dentist are neither necessary nor recommended for patient's dental health
- Fluoride application is limited to one per year to age 18.
- Loss or theft of dentures, bridgework or night guard
- Services which cannot be performed because of general health, physical or psychological limitation of patients
- Services performed by a non-participating provider are not covered
- Not to be combined with any other dental coverage
- Services that are not performed in our facility
- Plan cannot be combined with any other dental discount or coverage.



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Your membership will be automatically renewed every year. You can cancel your membership at the end of your 1 year period. However, you will be ineligible for re-enrollment for two years from date of termination.

Payment Instructions

A check may be submitted for the first payment on your policy. Thereafter, all premiums must be paid using Electronic Funds Transfer (EFT) from your credit card or checking account. Payments will be withdrawn every year.

Please complete the following information for payment by EFT:

Type of Account (Choose one) Visa Mastercard AMEX Discover/Novus
 Checking Cash

Name on Account _____

Card Number _____

Expiration Date _____ CW2 Number _____

Name of Financial Institution _____

Financial Institution's City, State, & ZIP Code _____

Bank Routing Number _____ Bank Account Number _____

Please attach a voided check to this application if you will be using your checking account for automatic payments.

I hereby authorize Young Dental Care to initiate debit entries from my above credit card or bank account for my Pearl Card.

Signed : _____ Date: _____

Any treatments require pre-payment before your appointment. Major treatments, such as a crown need at least 50% down payment before your appointment. Your payment must be made from your credit card or checking account. Your payment for the upcoming renewal period will be deducted from your account one week before your policy expires. If there are insufficient funds in your account for payment of premium on due date, payment will be due at time of 1 year recare appointment. If there are still insufficient funds, Smile Now Dental will immediately terminate your contract for nonpayment of premium, effective the last day of the period for which payment was received.

In making this application to Young Dental Care for Smart Savings Plan under this policy, I agree and understand that this application will become part of this policy and I agree to be bound by the terms of the policy issued by Young Dental Care. I further agree that the membership requested is subject to the approval of Young Dental Care and that no representative has the authority to make changes or modify this application for membership.

I hereby certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misinterpretation of submitted data may cause this application and subsequent policy to be null and void.

I have read and understand all terms, plan exclusions and limitations. Your policy will become effective upon receipt of your first membership premium.

Signed : _____ Date: _____