THE DENTAL GYM IN-HOUSE DENTAL PLAN

PRIMARY MEMBER

First Name: _____

Last Name: _____

Address: _____

Phone: _____ **Date of Birth** / /

E-mail: _____

S.S # / / **Female | Male**

SPOUSE

First Name: _____

Last Name: _____

Address: _____

Phone: _____ **Date of Birth** / /

E-mail: _____

S.S # / / **Female | Male**

DEPENDENT 1

First Name: _____

Last Name: _____

Address: _____

Phone: _____ **Date of Birth** / /

E-mail: _____

S.S # / / **Female | Male**

DEPENDENT 2

First Name: _____

Last Name: _____

Address: _____

Phone: _____ **Date of Birth** / /

E-mail: _____

S.S # / / **Female | Male**

Enrollment Period / / **to** / /

_____ _____

Signature of Primary Member **Date**

Method of Payment

CASH **CHECK** **MasterCard** **Visa** **Discover** **American Express**

Card # _____

Expiration Date: /

CVW Code: _____

Checks payable to RICHARD T. CARLYLE, DDS