56 Market St. • Po Box 576 • Eagle CO, 81631 • (970) 328-1116
castlepeakdental.com • castlepeakdental@centurytel.net

Dental Savings Plan Application Form

Castle Peak Dental Saving Plan Premiums:

- **Single--$359** (ages 14 and over)
- **Dual--$699** (This plan is for Spouses or Parent/Child 14 and over)
- **Family (3 members)--$958** (This plan includes family members and children under 18 or children who are enrolled in college full-time until the age of 23)
- **Family (4 members)--$1,197** (This plan includes family members and children under 18 or children who are enrolled in college full-time until the age of 23)
- **Each additional Child Plan--$179- Family's with 3 or more children** (ages 13 and under)
- **Each additional Teen Plan--$349- Family's with 3 or more children** (ages 14- 18 or a Full-time college student to age 23)

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- **Child plan--$259- Can only be combined with the Single Plan or purchased with additional child/teen plans--** (ages 13 and under)

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Policy Effective Date: _____

Total Amount Due for all Covered Family Members $_____

Primary Plan Holder Information:

Full Name:_____Birthdate:_____
Address (physical and P.O. Box):

_____

City: _____State:_____Zip:_____

Best Contact phone number: _____

Additional Family Members to be covered:

Name:_____Birthdate:_____Age:_____

Relationship:_____

Name:_____Birthdate:_____Age:_____

Relationship:_____

Name:_____Birthdate:_____Age:_____

Relationship:_____

Name:_____Birthdate:_____Age:_____

Relationship:_____

By signing below, I acknowledge that I have read the Dental Savings Plan brochure and understand plan details, benefits, and limitations. I acknowledge the annual fee is required at enrollment and cannot be financed. Membership fees for the Dental Savings Plan are NON-REFUNDABLE. I understand this is NOT a dental insurance, but a savings plan offered only at Castle Peak Dental. Castle Peak Dental reserves the right to modify, change or discontinue the Dental Savings plans, terms, fees and services offered at the company's discretion upon written notice from Castle Peak Dental prior to your anniversary date.

Signature: _____Date_____

Ask us about our Auto-renewal Program:
Sign up NOW and SAVE 5% off next year's premium!

Dental Saving Plan- Auto Renewal Form

Policy Holder Name:_____

Effective Date:_____

Payment Method for Auto-Renewal:

- ☐ Cash (in office only-prior to renewal date with completed application)
- ☐ Check (make checks payable to Castle Peak Dental- prior to renewal date and completed application mailed with check)
- ☐ Credit Card (payment made prior to renewal date with completed application)

Name on card _____

Card #_____

Exp date: _____CVC: _____

*****I, _____, authorize Castle Peak Dental to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Castle Peak Dental will notify when my plan is renewed, for my records. If I choose to discontinue participating in the dental savings plan, I will notify Castle Peak Dental ONE MONTH prior to my anniversary date.**

Signature for auto renewal: _____Date_____