MTWest Dentist
PERSONAL. PREVENTATIVE. PROFESSIONAL.

For office use only
Start Date: _____
End Date: _____

APPLICATION FOR DENTAL SAVINGS PLAN

Print clearly in black or blue ink, and answer all questions or indicate "not applicable" (i.e. N/A).

Your Profile

Name _____ DOB _____
Last First MM/DD/YYYY

Your Spouse/Partner Profile

Name _____ DOB _____
Last First MM/DD/YYYY

Your Children/Grandchildren

Name _____ DOB _____
Name _____ DOB _____
Name _____ DOB _____
Name _____ DOB _____
Name _____ DOB _____

Choose Your Savings Plan

☐ Single $439
☐ Dual* $839
☐ Family (3)* $1189
☐ Family (4)* $1489
☐ Each add'l member (5th+ person), $249 per member*

* Dual and Family Plans may include Spouse/Partner and Children/Grandchildren under the age of 24

◆ *Number of additional members* _____

Renewal of your discount plan receives 5% off your next premium. Ask our front desk team for details.

_____ _____
Member Signature Date

1. Mail this completed application with appropriate payment (check or credit card) to:
2. Make checks payable to **MT West Dentist**
3. Your membership starts **the day your full payment is processed**

MT West Dentist
PO Box 837
Plains, MT 59859

Credit Card: ☐ Visa ☐ Discover ☐ MasterCard ☐ AMEX
Credit Card Number_____
Exp Date_____ CVV_____ ZIP assoc'd with card_____

Authorized Signature_____