



## Enrollment Form

### Member Information (Please Print)

First Name	Last Name	Date of Birth
Home Address	City	State Zip
Home Phone	Work Phone	E-Mail

### Eligible Person(s) To Be Covered

1			
2			
3			
4			
5			
Name	Birth Date	Relationship	

*I wish to enroll in the Appleton Dental Plan as indicated. I acknowledge that I have read the enclosed information, which includes the fee schedule, summary of benefits, limitations and exclusions, and emergency procedures. I certify that the information on the application is true and complete. I agree to be bound by the terms and conditions of the Appleton Dental Plan without limitations, as listed on the Fee Schedule. This authorization is valid for 12 months from my effective date. A photocopy of this authorization shall be as valid as the original. I am entitled to receive a copy of this authorization form.*

**Member's Signature**

**Date**

Appleton Dental Plan  
18325 N. Allied Way #115B  
Phoenix, Arizona 85054

Phone: 602 - 957-6453

Fax: 480 - 941-4390

Email: [info@appletondentalplan.com](mailto:info@appletondentalplan.com)