



Dental Plan Application (Plan 504 - 500 Series)

Mr. Ms FIRST NAME _____ LAST NAME _____
 STREET _____
 CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ WORK PHONE _____
 TYPE OF BUSINESS _____
 DATE OF BIRTH _____ SS# _____

CHECK THE PLAN YOU WANT BELOW (Includes \$10.00 annual application fee)

- | | |
|---|--|
| <input type="checkbox"/> <i>Member Only , One Year, \$55.95</i> | <input type="checkbox"/> <i>Member Only, Two Years, \$101.90</i> |
| <input type="checkbox"/> <i>Member + 1, One Year, \$89.95</i> | <input type="checkbox"/> <i>Member + 1, Two Years, \$169.90</i> |
| <input type="checkbox"/> <i>Member + Family, One Year, \$120.95</i> | <input type="checkbox"/> <i>Member + Family, Two Years, \$231.90</i> |

DEPENDENT INFORMATION (ONLY LIST COVERED INDIVIDUALS)

FIRST NAME	RELATION	SOCIAL SECURITY #	SEX	DATE OF BIRTH

I understand the terms and conditions of the dental plan and agree that any dental procedure which is performed by a non-participating dentist will not be covered under the dental plan. In addition, all membership rates and fees will be fully earned by the company with no refunds.

I understand that the fully completed (signed/dated) original application and total amount due must be received by PLCSI no later than the 20th of the month prior to the month for which coverage is to be effective. Coverage will be effective on the 1st of the month.

Subscriber's Signature X _____ **Date:** _____

Please fill out and sign your completed application and mail it, with your check made payable to:
PLCSI - 24 South Broadway, Tarrytown, NY 10591