HoālaDentalPlan

PAYMENT FORM

APPLICANT INFORMATION Please Enter Clearly

Last Name | First Name | Email Address

Date of Birth (month/day/year) | Sex (m/f) | Telephone Number | Alternate Number

Mailing/Billing Address | City | State | Zip Code

DEPENDENT INFORMATION

Last Name	First Name	Middle Initial	Sex (M/F)	Date of Birth (month/day/year)
Spouse				
Child				
Child				
Child				

PLAN SELECTION
(Price includes Sales Tax of 4.712%)

❑ **Individual**	❑ **Family of 2**	❑ **Family of 3+**
$208.38/year	$302.62/year	$365.44/year

PAYMENT INFORMATION

❑ Check: payable to Hawaii Family Dental Centers

❑ Visa ❑ MasterCard ❑ American Express ❑ Discover Card

Card Holder Name _____

Card Number _____

C V V (security Code)_____ Expiration Date _____

Signature _____ Date _____

TERMS AND CONDITIONS

CONDITIONS OF ENROLLMENT: As a Ho'āla member, I hereby agree: (a) that the Ho'āla Dental Plan is not an insurance policy; it is an agreement for the provision of dental services with Hawaii Family Dental at a discounted price; (b) that the discounted fees provided by the Ho'āla Dental Plan are only for services provided by Hawaii Family Dental; (c) to pay the out-of-pocket costs at the time the services are received; (d) membership is 12 months and there are no refunds given for cancellations; (e) benefits will begin upon receipt of form and payment.

Signature of Applicant _____ Date _____