



### Comprehensive Dental Plan

## Application

New  Renewal

Print clearly in blue or black ink, and answer all questions or indicate "not applicable."

Preferred Dental Office Location: \_\_\_\_\_ Referred by: \_\_\_\_\_

#### Your Profile

Name \_\_\_\_\_ Sex: M F E-Mail Address \_\_\_\_\_  
 Last Four Digits of SSN \_\_\_\_\_ or Driver's License # \_\_\_\_\_  
 Address (not a P.O. Box) \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone number \_\_\_\_\_ Work phone number \_\_\_\_\_ Cell phone number \_\_\_\_\_

#### Your Spouse Profile

Name \_\_\_\_\_ Sex: M F E-Mail Address \_\_\_\_\_  
 Last Four Digits of SSN \_\_\_\_\_ or Driver's License # \_\_\_\_\_  
 Address (not a P.O. Box) \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone number \_\_\_\_\_ Work phone number \_\_\_\_\_ Cell phone number \_\_\_\_\_

#### Your Children

Name _____	Sex: M F	Age _____	Last Four Digits of SSN _____
Name _____	Sex: M F	Age _____	Last Four Digits of SSN _____
Name _____	Sex: M F	Age _____	Last Four Digits of SSN _____
Name _____	Sex: M F	Age _____	Last Four Digits of SSN _____
Name _____	Sex: M F	Age _____	Last Four Digits of SSN _____

Member Signature \_\_\_\_\_

Date \_\_\_\_\_

Please mail this completed application with appropriate payment (check or credit card) to:  
**Mortenson Family Dental**  
 Attn: Comprehensive Plan  
 P.O. Box 43193  
 Louisville, KY 40253  
 (502) 254-8535

Make checks payable to Mortenson Family Dental.

**Circle One**

**Single \$227.00** → For 1 Adult or 1 Child

**Dual \$439.00** → For Parent/Child, Husband/Wife or Child/Child  
 Includes children enrolled full-time in college until age 25, or children not enrolled full-time in college until age 18

**Family \$698.00** →

Credit Card Number: \_\_\_\_\_ CVV: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(Three Digit Code)

Authorized Signature: \_\_\_\_\_ **Visa MasterCard**