King of Prussia Dental
DENTAL ASSOCIATES GROUP MEMBER

Enrollment Application for In-House Dental Plan 2024

Name _____ _____ _____
Last *First* *Middle*

Address _____

_____

_____

Phone _____ _____
Home *Cell*

Date of Birth _____

Email _____

Dependents

Name	DOB	Relationship

Enrollment Fee

Single Member	**$350.00**	
Additional Member(s)	**$325.00** (each)	**TOTAL** = _____

Effective Date - _____ Renewal Date - _____

I, _____ do hereby understand the policies and limitations of the ***King of Prussia Dental Associates In-House Dental Plan***. Furthermore, I understand the office policies of King of Prussia Dental Associates and agree to them.