SAVINGS PLAN

Select a program: ☐ Individual Child ☐ Single ☐ Dual ☐ Family

Please answer all questions or indicate "not applicable"

PERSONAL INFORMATION

First Name: ______________________ Last Name: ______________________

Birthday: ______________________

Mailing Address: ______________________

Street Address: ______________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________

Email Address: ______________________

SPOUSE'S/PARTNER'S PERSONAL INFORMATION

First Name: ______________________ Last Name: ______________________

Birthday: ______________________

Cell Phone: ______________________

Email Address: ______________________

CHILDREN

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

First Name: ______________________ Last Name: ______________________

____

Member Signature Date

____

Parent or Guardian Signature (if child is under 18) Date

After the initial term of the one (1) year contract, this agreement shall be deemed renewed automatically each year for an additional one (1) year period, unless canceled via email or a phone call within thirty (30) days of the current term expiration date. You will receive an email 45 days and 30 days in advance of your contract end date. At that time, if you want to cancel your auto-enrollment, please respond to the email or call the clinic directly. If you forget to respond/cancel, we can refund you in full as long as no benefits have been used for that renewal period.

A recurring payment authorization form is required to be completed.