3 Leefield Gate
Melville, NY 11747

Low-Cost Individual Dental Coverage

Please Fill Out & Send This Form in Today to Begin Coverage!

First Name _____

Last Name _____

Middle Initial _____ Female / Male

Home Address _____

_____

City _____ State _____ Zip _____

Phone _____

Email _____

Date of Birth _____/ _____/ _____ S.S.# _____ - ____ - _____

Spouse First Name _____

Spouse Last Name _____

Spouse Middle Initial _____ Female / Male

Spouse Date of Birth _____/ _____/ _____ S.S.# _____ - ____ - _____

Enrollment Period _____ to _____

***** **Valid for one year from date of sign-up.**

Signature (member & spouse)

_____ Date _____

_____ Date _____

MasterCard / Visa / Discover / American Express

Card Number _____

Expiration Date _____/ _____ CSV _____

***Please make check payable to: **Gress Dental Excellence**

Please List All unmarried Children Up To Age 20:

1. Child's Name _____ Middle Initial _____
   Date of Birth _____/ _____/ _____ Son / Daughter

2. Child's Name _____ Middle Initial _____
   Date of Birth _____/ _____/ _____ Son / Daughter

3. Child's Name _____ Middle Initial _____
   Date of Birth _____/ _____/ _____ Son / Daughter

4. Child's Name _____ Middle Initial _____
   Date of Birth _____/ _____/ _____ Son / Daughter

5. Child's Name _____ Middle Initial _____
   Date of Birth _____/ _____/ _____ Son / Daughter