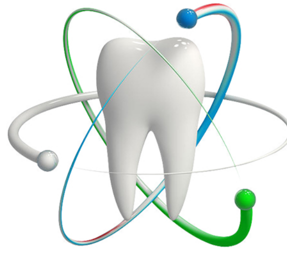

MacabiSave Application

Mail To: MACABI DENTAL ASSOCIATES 1025 NORTHERN BLVD., SUITE 105 ROSLYN NY 11576

First Name: ______________________________ MI ____________

Last Name: ______________________________ D.O.B. _____/_____/_____

Street Address: ____

City: ______________________ State __________ Zip ____________

How Did You Hear About MacabiSave? __________________________________

Additional Household Family Members:

Name: ______________________________ D.O.B. _____/_____/_____

Name: ______________________________ D.O.B. _____/_____/_____

Name: ______________________________ D.O.B. _____/_____/_____

Name: ______________________________ D.O.B. _____/_____/_____

Select Type of Membership: Please circle one

PLAN	1 YEAR	2 YEAR	3 YEAR	4 YEAR
Single	$99.00	$189.00	$249.00	$349.00
Couple	$179.00	$299.00	$429.00	$549.00
Family	$199.00	$369.00	$489.00	$599.00

Payment Type: Please make all checks payable to Macabi Dental Associates

Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ Check

Card Holder's Name ____

Card Number: ______________________________ Expiration _____/_____/_____

CVV Code: ______________

Signature: ______________________________ Date _____/_____/_____