DENTAL SAVINGS PLAN AUTO-RENEWAL

AUTOMATIC PAYMENT DISCLOSURE

This form outlines your agreement with Bel Drive Dental, in which you authorize us to process electronic payments from the credit card, debit card, or bank account provided below. You will be automatically charged the annual Dental Savings Plan contract renewal fee on the start date listed below. Payments will continue annually until the end date has been satisfied or your contract has been cancelled at your request. You will receive renewal information 45 days prior to your renewal date.

If there are changes to the fees, you will be notified at this time. **If you wish to cancel your contract, you must provide a written notification thirty (30) days before your current term renewal.** Please provide Bel Drive Dental with a minimum 48 hour notice, should you need to edit a payment for any reason. If you are unable to fulfill the agreement, it will be your reasonability to contact Bel Drive Dental to discuss alternate payment options. You will not receive any further correspondence from

Bel Drive Dental regarding these payments if your account remains in good standing.

A receipt for payments completed will be available upon request.

Patient Name: _____

Last 4 digits of Card/Bank Account: _____

Card Expiration Date: _____

Renewal Start Date: _____

Plan Selected:

☐ CHILD ☐ SINGLE ADULT ☐ DUAL ☐ FAMILY

*how many family members on plan:____

Patient Signature
(Parent/Guardian if under age of 18): _____

Date: _____

Card Holder/Bank Account
Authorizing Signature: _____

Date: _____