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## BHD Membership Plan

First Name \_\_\_\_\_ Last Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please list below any additional people you would like to enroll in the BHD Membership Plan:

Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Effective Date: \_\_\_\_\_ *(The enrollment period is valid for one year from this date.)*

Enrollment Fee	Number	Total
Adult \$410	X _____	_____
Child \$375 (less than 14 years old)	X _____	_____
	<b>Total</b>	_____

*(I am aware an additional \$25 will be added per person if paying with Care Credit or another 3<sup>rd</sup> party financing option.)*

Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand the benefits, limitations, and requirements of the BHD Membership Plan and agree to the terms. Payments are due at time of registration and service to receive discounts. This is not an insurance product.