LRD Savings Plan Registration

Patient Name : _____ _____ ____
Last First M.I.

D.O.B : _____ E-mail: _____

Address : _____

_____
City State Zip

Phone Number : (Cell)_____ (Home)_____ (Work)_____

Please select the plan you prefer.

_____ Individual : $99/Year
_____ Family of 2: $179/Year
_____ Family of 3: $219/Year
_____ Family of 4: $249/Year
_____ # additional family member after 4

* $20 per additional family member after 4
* All membership fees are due in full at the time of sign-up and the fees are non-refundable. The savings plan is valid for 12 months from the sign up date.

Covered Plan Members :

Name : _____ D.O.B : _____
Name : _____ D.O.B : _____
Name : _____ D.O.B : _____
Name : _____ D.O.B : _____

Total Due $_____

I acknowledge that I have read Guidelines & Limitations on LRD savings plan brochure/website and fully understand the plan features, restrictions and all the contents.

Name : _____ Signature _____ Date _____

Office Use

*Payment Method : Check ____ Cash ____ Credit/Debit Card ____ PayPal _____

*Membership Number: _____

*Location of Registration: _____ *Date of Registration: _____