Renewal Date _____/_____/_____

BRITT DENTAL CARE

Dental Savings Plan Enrollment Form

PERSONAL INFORMATION

Name _____ ☐ Male ☐ Female
Last First Middle Preferred

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____/_____/_____ SSN _____-_____-_____

SPOUSE INFORMATION

Name _____ ☐ Male ☐ Female
Last First Middle Preferred

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____/_____/_____ SSN _____-_____-_____

CHILDREN INFORMATION

Name _____ ☐ Male ☐ Female Birthday _____/_____/_____

Name _____ ☐ Male ☐ Female Birthday _____/_____/_____

Name _____ ☐ Male ☐ Female Birthday _____/_____/_____

Name _____ ☐ Male ☐ Female Birthday _____/_____/_____

BRITT DENTAL CARE PLAN

_____ Adult Plan (Age 15 and over) $325 x _____ = _____
** Children under age 3 included with Adult Plan **

_____ Child Plan (Ages 3-14) $285 x _____ = _____

TOTAL ANNUAL COST = _____

Please INITIAL beside each Limitation and Exclusion

_____ Participation cannot be used in conjunction with a dental insurance policy and cannot be combined with any other discount or financing including CareCredit.

_____ Annual premiums for each family member are non-refundable, even if the plan benefits are not fully utilized during the participation period. No refunds will be given for cancellations.

_____ Enrollment date begins on the first date of use and provides coverage for 12 months to the date. Enrollment is available on a yearly basis only. The program renews each year and the current applicable annual premium must be paid on the renewal date for benefits to renew. Rates are subject to change annually.

_____ Program benefits may only be applied to work performed at Britt Dental Center and cannot be applied to any specialist to whom we refer. They will not honor this discount.

_____ Any costs associated with dental treatment is expected to be paid in full at the time of service to receive the 15% discount. Any service not paid for at the time of service will be billed at our standard non-discounted rate.

_____ The included exams, x-rays, cleanings, and fluoride treatment must occur within the 12-month period of enrollment and cannot be carried over to the next enrollment period.

_____ It is the patient's/parent's responsibility to make and keep appointments for his/her family members. A broken appointment fee of $50 per 60 minutes scheduled will be incurred for each broken appointment without a 24-hour advance notice.

_____ Plans are not transferable to another party or uncovered family members.

_____ All fees shall be based on our practice's usual, customary, and reasonable fees, which are subject to change, and not any other dental insurance plan's fees.

_____ This plan cannot be used in Workers' Compensation Treatment Plans or with any dental treatment needed as a result of injury where a lawsuit is involved.

_____ Benefit coverage is effective for participants who remain enrolled in the plan throughout the entire duration of recommended treatment. If enrollment expires before treatment is completed, coverage or discounts on procedures are no longer available.

_____ _____

Patient or Guardian's Signature Date

BRITT DENTAL CENTER

FAMILY, COSMETIC, AND IMPLANT DENTISTRY