



For Office Use Only:
 Effective Date: _____
 Renewal Date: _____

SmartSmile Dental Savings Plan 2017

Application New Renewal

Print clearly in ink and answer all questions or indicate "not applicable."

Your Profile

| | | |
|------------------------|-------------------|--------------------------------|
| Name | Sex: M F | Email Address |
| Date of Birth: | Social Security # | Driver's License # |
| Address (not a PO Box) | | |
| City | County | State Zip |
| Home Phone # | Work Phone # | Cell Phone # |

Your Spouse Profile

| | | |
|------------------------|-------------------|--------------------------------|
| Name | Sex: M F | Email Address |
| Date of Birth: | Social Security # | Driver's License # |
| Address (not a PO Box) | | |
| City | County | State Zip |
| Home Phone # | Work Phone # | Cell Phone # |

Your Children

| | | | |
|------|----------|----------------|--------------|
| Name | Sex: M F | Date of Birth: | Son/Daughter |
| Name | Sex: M F | Date of Birth: | Son/Daughter |
| Name | Sex: M F | Date of Birth: | Son/Daughter |
| Name | Sex: M F | Date of Birth: | Son/Daughter |
| Name | Sex: M F | Date of Birth: | Son/Daughter |

By signing below, I acknowledge that I have read the brochure and understand the plan benefits, limitations and requirements of the plan and agree to the terms. Payments are due at time of service. All family members must reside in the same household. This is not an insurance product.

Member Signature _____ **Date** _____

The plan is only honored at Jansen Family Dentistry

The SmartSmile Savings Plan is not an insurance plan that can be used with any other dental office.

Please mail this completed application with appropriate payment (check or credit card) to:

Jansen Family Dentistry
710 Averitt Road, Suite C
Greenwood, IN 46143
(317) 888-6111

| | |
|---------------|--|
| Single | \$382.00 |
| Dual | \$706.00 |
| Family (3) | \$916.00 |
| Family (4) | \$1241.00 + \$252.00 each add'l member |
| Perio Program | \$647.00 |

Credit Card # _____ Expiration Date: _____ Total: _____
 Authorized Signature: _____ Visa/MasterCard/Discover/American Express

Care Credit (12 monthly payments upon approval) – An additional 13% administrative fee will be applied if using Care Credit.

- PROGRAM EXCLUSIONS AND LIMITATIONS**
 The program is a discount plan, not a dental insurance plan and is secondary to any other dental plan. It cannot be used:
- In conjunction with another dental plan
 - For services for injuries covered under workman's compensation
 - For treatment, which, in sole opinion of the treating dentist or doctor, lies outside the realm of their capability
 - For referrals to specialists
 - For hospitalization or hospital charges of any kind
 - For costs of dental care which is covered under automobile or medical insurance
 - For dental treatment in progress

- PROGRAM GUIDELINES**
- There will be a \$50 reinstatement fee if your plan lapses
 - Cannot be used in conjunction with another dental plan
 - NON-REFUNDABLE
 - No refunds or premiums will be issued at any time if participant decides not to utilize dental plan
 - Not transferable
 - Patient's portion of bill is due day of service
 - No additional cash discounts will apply
 - There will be a \$25 Broken Appointment Fee without 48 hour notice
 - A second Broken Appointment without 48 hour notice nullifies participation in plan and all fees are forfeited

*The SmartSmile Dental Savings Plan expires one year after activation. Enrollment fees and member discounts are subject to change at each renewal.