

YOUR MONEY, YOUR CHOICE

DENTAL MEMBERSHIP PLAN



510 East State Street
Mauston, WI 53948

(608) 847-5614

improveyoursmile@wdimprovements.com

Taking charge of your oral health is now easier than ever. Wisconsin Dental Improvements is proud to offer a dental membership plan for all patients that do not carry dental insurance*.

*patients that elect to use ***Your Money, Your Choice*** Membership Benefits in lieu of dental insurance must sign a waiver.

MEMBERSHIP PLAN DETAILS

| AGE | 1ST MEMBER | ADDITIONAL MEMBER | ANNUAL BENEFIT |
|----------------|------------|-------------------|----------------|
| 12 years old + | \$499 | \$449 | \$1,200 |
| 0-11 years old | \$399 | \$349 | \$800 |

>50% Annual Cost Savings

*Health is the greatest possession.
Contentment is the greatest treasure.
Confidence is the greatest friend.*

-Lao Tzu



PLAN COVERAGE



What's Covered:

- Exams
- Radiographs
- 3D Dental Radiographs
- Dental Cleanings
- Fillings
- Tooth Supported Crowns
- Extractions
- Conventional dentures
- Emergency visits
- Nitrous Oxide

Exclusions:

- Dental Products – electric toothbrushes, toothpastes, oral hygiene adjuncts
- Specialty Services – Dental Implant Services, Implant Dentures, Cosmetic Dentistry, Full Mouth Reconstruction, Airway Centered Dentistry

BENEFIT PLAN ILLUSTRATION

Routine Care Scenario

Patient A: I want my regular dental cleanings and emergency visits only.

| | Before Benefits Applied | After Benefits Applied, Your Cost |
|--|-------------------------|---------------------------------------|
| 2 dental cleanings, 2 dental exams, 1 set of bitewing radiograph, 1 emergency visit and radiograph | \$700 | \$0 <i>\$500 Remaining benefit</i> |

More involved Dental Care Scenario

Patient B: I know I need more than regular cleanings and I have unfinished dental work.

| | Before Benefits Applied | After Benefits Applied, Your Cost |
|---|-------------------------|-----------------------------------|
| 3 Periodontal cleanings, 2 dental exams, 1 set of bitewing radiograph, 1 filling in a molar tooth | \$1,375 | \$175 |

These are limited illustrations of the plan benefits. Schedule a call to discuss how this plan can help you save money. This can be combined with other health plans such as Health Savings Accounts and Flex Spending Plans to minimize your annual health costs.

YOUR MONEY YOUR CHOICE GUIDELINES

1. Membership dues are payable in full upon enrollment and are non-refundable.
2. Cash, check or credit payments are accepted. No additional cash courtesy applied to services within plan allowance maximum.
3. Membership will NOT automatically renew on the anniversary enrollment. It is your responsibility to renew 30 days in advance by contacting us.
4. Payments for additional dental services are the members' responsibility.
5. Payment is due on the date of service to qualify for the discounts detailed in the membership plan.
6. Membership must be current to receive the discount.
7. Fees for dental services may change at any time.
8. It is the member's responsibility to schedule and keep all appointments offered as part of the Membership Program.
9. Please notify our office at least 48 hours in advance if you must change a scheduled appointment.
10. Benefits will not carry beyond membership expiration date if you voluntarily change your appointment.
11. No deductibles, no pre-authorizations, no waiting periods.
12. No other discounts apply.
13. No refunds.
14. Unused benefits do not rollover to the next membership year.

MEMBERSHIP FORM

Membership Application



WISCONSIN
DENTAL
IMPROVEMENTS

Person To Be Covered By The Plan

| | | | | | | | | | | |
|--------------------------------------|---|------------------------------|-----------------------------|-------------------------|----------------------|------------------------------|-----------------------------|----------------------|----------------------|----------------------|
| First Name | : | | | | | | | | | |
| Last Name | : | | Date Of Birth | : | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | | | | | D | D | M | M | Y | Y |
| Full Address | : | | | | | | | | | |
| State | : | | Postcode | : | | | | | | |
| Phone Number | : | | City / Country | : | | | | | | |
| E-Mail | : | | | | | | | | | |
| Does Patient Carry Dental Insurance? | : | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insurance Waiver Signed | : | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Responsible Party

| | | | | | |
|----------------|---|--|---------------------|---|--|
| First Name | : | | Last Name | : | |
| Street Address | : | | | | |
| City / Country | : | | State / Provenience | : | |

Consent to Authorize WDI to process Membership Plan Fee

| | |
|----------------------|------------------------|
| Today's Date | Payment Type Submitted |
| <input type="text"/> | <input type="text"/> |
| Effective until: | |

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WI 53948

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Additional : ☐ Yes ☐ No
family member

Signature

ADDITIONAL FAMILY MEMBERSHIP

Person To Be Covered By The Plan

First Name

:

Last Name

:

Date Of Birth

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First Name

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Last Name

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Date Of Birth

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INSURANCE WAIVER



By signing below, I, _____, acknowledge that:

- I elect to use My Money, My Choice dental membership plan offered by Wisconsin Dental Improvements.
- I am aware that My Money, My Choice is NOT dental insurance
- Once I elect to participate in My Money, My Choice membership plan, I cannot rescind my participation and have dental services claims submitted to my dental insurance to try and collect payment.
- I am aware that no insurance claims have been submitted by another party during enrollment year.

Printed Name

Signature

Date Signed:

I, the undersigned, have read and fully understood the terms and conditions of signing this Insurance waiver.

I also certify that I am

☐ at least 18 years of age or

☐ parent or guardian that membership member is enrolled under

☐ I currently have active dental insurance.

Your Health is Your Wealth