# WISCONSIN DENTAL IMPROVEMENTS

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 WDI Dental Membership Benefits in lieu of dental insurance must sign a waiver.

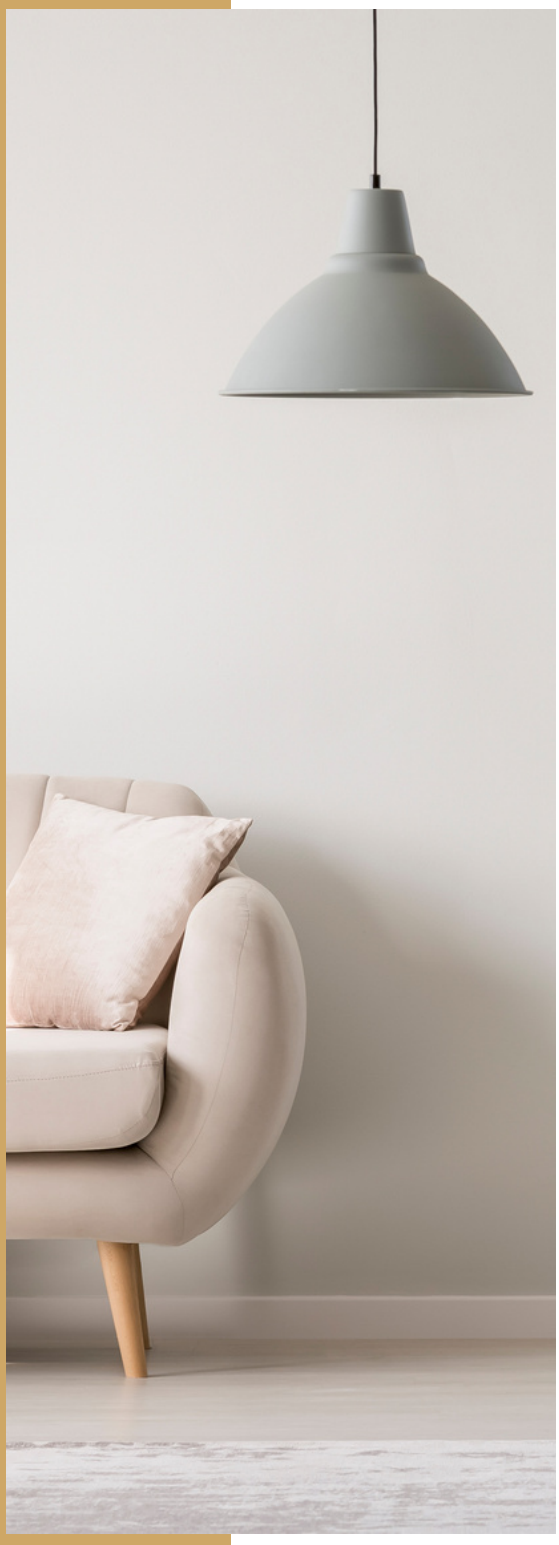
# MEMBERSHIP PLAN DETAILS

| AGE | 1ST MEMBER | ADDITIONAL MEMBER | |
|---|---|---|---|
| 12 years old + | $499 | $449 | |
| 0-11 years old | $499 | $449 | |
| Periodontal Patients | $875 | $825 | |

*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

**WDI Adult (12 & older) &**
**Child Memberships includes:**

(2) Routine Adult or Child Cleanings
(2) Periodic Oral Evaluations including Oral Cancer check
(1) Set of (4) Bitewing xrays

**WDI Periodontal Membership includes:**

(3) Periodontal Cleanings
(2) Periodic Oral Evaluations including
Oral Cancer check
(1) Set of Vertical Beitweing Xrays 7-8 films

***There will be a 15% courtesy on additional listed dental services for Cash or Ck payments***
***& 13% for credit card payments up to a max of $1500 annually.***

***Schedule or 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.***

# WDI DENTAL MEMBERSHIP 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 : D D M M Y Y

Full Address :

State :

Postcode :

Phone Number :

City / Country :

E-Mail :

Does Patient Carry Dental Insurance? : Yes No

Insurance Waiver Signed : Yes 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

Effective until:

Additional family member : Yes No

Signature

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# ADDITIONAL FAMILY MEMBERSHIP

## Person To Be Covered By The Plan

First Name :

Last Name :

Date Of Birth : D D M M Y Y

First Name :

Last Name :

Date Of Birth : D D M M Y Y

First Name :

Last Name :

Date Of Birth : D D M M Y Y

First Name :

Last Name :

Date Of Birth : D D M M Y Y

First Name :

Last Name :

Date Of Birth : D D M M Y Y

First Name :

Last Name :

Date Of Birth : D D M M Y Y

# INSURANCE WAIVER

WDI WISCONSIN DENTAL IMPROVEMENTS

By signing below, I, _____, acknowldege that:

- I elect to use WDI dental membership plan offered by Wisconsin Dental Improvements.
- I am aware that WDI dental membership plan  is NOT dental insurance
- Once I elect to participate in WDI 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.