STAR CITY DENTAL SAVINGS PLAN

Star City Dental Savings Program is a **one (1) year contract**, starting from the date of the signed contract between the patient and Star City Dental. Our dental savings program is designed to provide access to affordable, quality dental care.

DENTAL BENEFITS INCLUDE:

- **Two Dental Prophylaxsis/Cleanings** (Adult Prophy, Perio Maintenance, or Child Prophy)
- **Two Exams: Comprehensive** (new patient), **Periodic** (recare), **Limited** (emergency)
- **Annual Radiographs** (Bitewings; Full Mouth Series or Panoramic Radiograph if necessary)
- **Two Fluoride Treatments**

*****ALL OTHER SERVICES OFFERED AT STAR CITY DENTAL ARE DISCOUNTED 15% OFF*****

COST:

- **Individual Child** (Age 13 and Younger) **= $325**
- **Single** (Age 14 and Older) **= $450**
- **Dual** (Married Couple) **= $800**
- **Family** (Three Members or More)
  - **1st Member = $400**
  - **2nd Member = $375**
  - **3rd Member = $350**
  - **Additional Members = $315 each**

EXCLUSIONS AND LIMITATIONS:

- This contract is only for services performed by a staff member of Star City Dental.
- This contract does not replace, eliminate, or modify any other contract with Star City Dental.
- This contract can not be used in addition to dental insurance.
- This contract does not give discounts on services already rendered.
- Family plans are limited to families of 3 people or more.
- Family members must live in the same household as the contract holder (unless attending college), are limited to immediate family members (parents and children), and are included in the family option up to the age of 20.
- Maximum allowed discount off any single procedure is $500.
- Payment must be made at time of service.
- Cannot be used or combined with any other discount or promotion.
- No refunds of premiums will be issued at any time if participant decides not to utilize plan.
- After the initial term of the one (1) year contract, this agreement shall be deemed renewed automatically each year for an additional one (1) year period unless canceled in writing within thirty (30) days of the current term expiration date.

STAR CITY DENTAL

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Select a program: ☐ Individual Child ☐ Single ☐ Dual ☐ Family

Please answer all questions or indicate "not applicable"

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Birthday: _____

Mailing Address: _____

Street Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____

SPOUSE'S/PARTNER'S PERSONAL INFORMATION

First Name: _____ Last Name: _____

Birthday: _____

Cell Phone: _____

Email Address: _____

CHILDREN

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Member Signature Date

Parent or Guardian Signature (if child is under 18) Date

After the initial term of the one (1) year contract, this agreement shall be deemed renewed automatically each year for an additional one (1) year period, unless canceled via email or a phone call within thirty (30) days of the current term expiration date. You will receive an email 45 days and 30 days in advance of your contract end date. At that time, if you want to cancel your auto-enrollment, please respond to the email or call the clinic directly. If you forget to respond/cancel, we can refund you in full as long as no benefits have been used for that renewal period.

A recurring payment authorization form is required to be completed.