Renewal Date:

30 Orchard Street Dover, NJ 07801 973-366-0311

Application for
***My Dental Concierge* Plan Membership**

Primary Member Name: ____ DOB:____________________

Address: ____ City: ________________________ St:______ Zip: ________

Email:____ Home: ______________________ Cell:________________________

Second Member Name:____ DOB:____________________

Dependent 1:____ DOB:___________________

Dependent 2:____ DOB:___________________

Dependent 3:____ DOB:___________________

Dependent 4:____ DOB:___________________

MEMBERSHIP DUES

First family member $250.00 Second family member $175.00 Each additional family member $125.00

TERMS AND LIMITATIONS

This is a dental discount plan and is NOT insurance. It cannot be combined with any dental insurance coverage.
Payment for all treatment is required IN FULL at time of service.
Discount applies to dental services only.
Plan benefits apply to treatment at Maser Dental ONLY and are NON-transferable. If you are referred to a specialist, this discount will not apply to services rendered by another dentist.
Benefits are available to registered Members ONLY. Substitution of non-members is not allowed. All participating family members must reside in the same household.
Dues are non-refundable. No refunds will be given if plan is not utilized within active membership period.
Discount will be reduced to *20%* if payment for treatment is financed through *Care Credit* due to required merchant fees.
Dental treatment required due to injury that involves litigation or other insurance such as auto, liability, workman's compensation, etc. will not be eligible for coverage under this plan.
Discounts under this plan cannot be combined with any other offers.
Effective date is the date the payment for dues is received. Membership is effective for one year from effective date.
Renewal will become effective only upon payment of annual dues.
Member is responsible for renewing before membership expires. Discount will not apply to services rendered during a lapse in membership.
Dues and treatment fees are subject to change annually.

By signing here, I acknowledge that I have read and understand the terms of this agreement and am authorized to sign on behalf of all parties listed above. I hereby consent to one year of membership in *My Dental Concierge* and understand that no refunds will be issued if I choose to terminate this membership prior to one year or if I do not utilize benefits within the active membership period.

____ ___________________

Signature *Date*

For Office Use Only

☐ *Payment Rec'd* ☐ *Entered in Dentrix* ☐ *Fee Sched* ☐ *Payment type*