What is Bay Area Dental Plan?

Bay Area Dental Plan is an annual plan that has been created to provide quality dental care for families and individuals at greatly reduced prices. Annual membership fee is $450 for an initial plan member and only $400 for each additional family member.

Who is Eligible?

You, your spouse and any dependent children under the age of 19 or full-time students up to age 23.

What are the Benefits?

- Regular teeth cleanings* (2 per year), examinations (2 per year) and annual x-rays at NO CHARGE
- Free fluoride varnish twice a year with routine dental cleanings
- 20% savings on all regular dental procedures
- 10% savings on all denture cases, implant restorations and multiple units/comprehensive cases
- 20% savings on all in-office dental prescriptions
- $50 co-pay for emergency visits

* ***The regular cleaning benefits, included in the membership, will be applied to the costs of Periodontal Maintenance cleanings. The difference in cleaning fees will be your responsibility at the time of service.***

When Will Benefits Begin?

Benefits will begin immediately. Members must remain in the plan a minimum of 12 months.

Limitations & Exclusions

- Demonstrated non compliance with recommended course of treatment
- Services which in the opinion of the attending dentist are neither necessary nor recommended for the patient's health
- Restorations, splints or other appliances used to increase vertical dimension or restore occlusion
- Any service(s) you are referred out of the office for; Periodontics, Orthodontics, Oral Surgery and Endodontics
- Hospital benefits for any dental procedure
- Loss or theft of dentures, bridges or crowns
- Any implantation or experimental procedures
- Services for injuries or conditions which are covered under Worker's Compensation or Employer's Liability laws
- Any services that cannot be performed because of the general health, physical or psychological limitations of the patient
- If a patient should become covered by a traditional dental insurance this plan becomes null and void with no refund fees

Last Name ______________________ First _______________________ MI ______

Home Address ____

City ____________________________ State _____________ Zip _______________

Home/Cell Phone ______________________ Work Phone ______________________

Birth Date ________________ Employer _____________________________________

Email _________________________

List covered dependents:

Name	Birth Date	Relationship

Total Amount Due $_____________

Please read and sign below:

I understand the benefits, limitations, exclusions and requirements of the Bay Area Dental Plan and agree to the following:

1. I will remain on the plan and pay membership fees for a minimum of 12 months.
2. Payment of less than 12 months membership fees may cause me to be charged the usual customary fees for all services (including those already provided) and my being charged for the remaining months fees in lump sum.
3. Fees for dental services are due when rendered. Fees for prosthodontics (dentures) and cast restorations (crowns, inlays, onlays & veneers) are due at the preparation/impression visit. If you choose not to pay at the time of service you will be billed our usual and customary fees for such services.
4. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs.

Signature ____________________________________ Date ______________________