



171 Grandview Ave. Suite 103
Waterbury, CT 06708

O: (203) 574-2725

F: (203) 574-2726

www.ctfdental.com

Dental Savers Plan

Connecticut Family Dental – Dental Savers Plan is an annual reduced fee dental plan that allows individuals and families to receive the same quality of care at reduced prices.

If not covered by any dental insurance plan, you and your spouse are eligible, as well as children under the age of 19. Children may be members only as dependents of adult members.

Benefits begin immediately. Members must remain in the plan a minimum of 12 months. All payments at the reduced fee level are made directly to Connecticut Family Dental on the day you sign up for membership in the Dental Savers Plan. The Dental Savers Plan is available to household family members only and cannot be transferred to persons outside the house hold.

BENEFITS

Your Connecticut Family Dental – Dental Savers Plan Membership **provides up to two simple teeth cleanings per year**, local anesthetics, yearly examinations, x-rays, Free Oral Cancer Screening (excluding fluoride, sealants and Zoom Whitening) at **NO CHARGE**. Your membership also provides you with a 10-25% reduction in our usual fees for other dental services. There are no yearly maximum or deductibles to meet and if dental coverage is obtained while on the Dental Savers Plan, members will be required to use the dental insurance and the membership plan will be terminated.

Emergency care: Eligible members and their eligible dependents may receive up to 2 emergency visits per year. All necessary treatment is provided at the reduced fee.

Orthodontics are not covered by this plan.



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PLAN FEES

1 Adult Member = \$149 annually

1 Child Member=\$99 annually

PATIENT PAYMENTS

All payments are made directly to the dental office. Payment plans are offered for any needed treatment, please speak to the staff for more details. This plan is only offered at our office located at 171 Grandview Ave Suite 103, Waterbury CT 06708. It is offered for care received during office hours only.

Dental Limitations, Rules, and Exclusions

- Orthodontic services provided by this office are NOT part of this membership plan.
- Does not apply to services not performed in this office.
- No refunds are issued.
- Hospital benefits for any dental procedure.
- Services, which in the opinion of the attending dentist, are neither necessary nor recommended for the patient's dental health.
- Loss or theft of bridgework or dentures.
- Services for injuries or conditions that are covered by Workers Compensation, Employer's Liability laws, Auto Insurance, Homeowner's, or ANY other insurance plan.
- Services that are provided without cost to the member.
- Services that cannot be performed because of general health, physical or psychological limitations of the patient.
- Members CANNOT have dental insurance coverage. If dental coverage is obtained while on the Connecticut Family Dental – Dental Savers Plan, members will be required to use the dental insurance and the membership plan will be terminated and no refund would be provided
- Failure to show or cancellation of a scheduled cleaning appointment without the required 24-hour notice will count as one of your cleaning occurrences and cannot be made up.
- Fees for endodontic procedures, prosthodontic and cast restorations are due at the preparation/impression visit unless a payment plan is established at the practice for the same procedures.
- Rules, limitations, and exclusions are subject to change without notice.



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MEMBER REGISTRATION

Last Name _____ First _____ MI _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Birth Date _____ Name of Employer _____

<u>List Covered Dependents</u>	<u>Birthdate</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<p><u>Plan Details:</u></p> <p>Type of plan: _____</p> <p>Payment amount : _____</p> <p># of cleanings per plan year: _____</p>
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Select Method of Payment

Circle one: **Visa, Mastercard, Discover, Debit card, Cash or Check**

I understand the benefits, limitations, exclusions, and requirements of the Plan and I agree to the following: **I will remain in the plan and pay membership fees for a minimum of 12 months.** Payment of less than 12 months membership fees may result in my being charged the usual and customary fees for all services, including those already provided. Fees for dental services are due as the services are rendered. Failure to comply may result in my being charged the usual and customary fees for those services. A late fee of \$2.00 per day will apply to accounts when there are not sufficient funds available in your account to clear your check payment when paying for services and/or initial yearly fees. I agree to pay any and all costs in collecting all charges including, but not limited to, attorney fees and court costs. Coverage must be continuous. Late fees must be made up for uninterrupted service. Fees are nonrefundable. If other dental coverage is obtained while on the Connecticut Family Dental – Dental Savers Plan members will be required to use the dental insurance and the membership plan will be terminated.

Signature (required) _____

FOR OFFICE USE:

Membership Start Date: _____ Membership End Date: _____