Hewlett Family Dental

Dental Membership Plan Application

☐ Single $295 ☐ Couple $495 ☐ Family (up to 4) $695

#____Additional Family Members at $150 each

Subscriber

Last Name: _____First Name_____ MI__

DOB ____/____/_____ Gender: M / F SSN (Last 4 Digits) _____

Address / PO Box _____

City_____ State _____ Zip_____

Primary Contact phone number _____ Email_____

Covered Family Members:

Name _____DOB_____/_____/_____ Gender M /F

Name _____DOB_____/_____/_____ Gender M /F

Name _____DOB_____/_____/_____ Gender M /F

Name _____DOB_____/_____/_____ Gender M /F

Name _____DOB_____/_____/_____ Gender M /F

Total Amount _____ ☐ Cash ☐ Check # _____

☐ Credit Card # _____

Expiration date ___/___ CW_____ Type_____

Cardholder name _____Zip Code _____

I understand the discounts and services provided with this plan, acknowledge all information is correct and payment for services is due the day of treatment. I understand that by signing this form I give authorization to charge my credit card for the above referenced enrollment fee.

Subscriber's Signature_____Date _____/_____

Hewlett Family Dental

Dental Membership Plan

Terms and Conditions

Family members eligible for the Dental Membership Plan ("Plan") offered by Hewlett Family Dental ("Office") may include initial member, spouse and unmarried children under the age of 26.

The Plan duration for all family members shall be 12 (twelve) months from the date the initial member signs the Plan agreement, regardless of the date the additional member(s) were added to the plan.

All Plan membership fees are due in full at the time the Plan Agreement is signed.

To avoid a reactivation fee*, plan members must renew their membership prior to the end of the 12 (twelve) month plan year. **If plan is not renewed prior to, or up to the date the plan expires member will be charged a fee to reactivate the plan.*

All additional charges for general dentistry and/or products are due at the time of service. Any charges not paid at the time of service will be billed at full cost.

Prior to the completion of the period, you shall have the opportunity to renew your benefits for an additional 12 month period.

This Plan may not be used in conjunction with any dental or health insurance, including workers' compensation.

This Plan may not be used in conjunction with any other discount, special offer, or other membership plan or program.

The discounts you and any covered Plan members will receive shall be for services provided by Hewlett Family Dental. Discount and covered services do NOT apply to any other office or provider, including any specialists you might be referred to by Hewlett Family Dental.

The Plan discount will not apply to dental care for which, in the sole opinion of the Hewlett Family Dental provider, lies outside the realm of their capability.

If a member uses Care Credit as payment for any services provided during the Plan period, the Plan discount is decreased to 15% due to merchant fees.

Plan discount does not apply to teeth whitening refill kits or other products purchased at Hewlett Family Dental.

Plan discount does not apply to orthodontic treatment.

The Plan discount is non-transferable: Plan is specific to each member. Plan members may not transfer their Plan discount to non-members.

Plan benefits and rates are subject to change on an annual basis.

By signing the Plan Agreement for the Dental Membership Plan ("Plan"), you are authorizing Mark E Hewlett DMD (Hewlett Family Dental) "Office" to process your credit card (if that is your preferred payment method), for the plan you have selected. By signing the Plan Agreement, you indicate that you have read and agree to the terms and conditions of the Plan.

Termination and Cancellation

Office reserves the right to terminate plan members from the Plan, or terminate the Plan itself for any reason. If Office terminates the plan or your membership, you will receive a pro-rata refund of your membership fee.

You have the right to cancel within the first 30 days from the date the initial member signs the Plan Agreement and receive a full refund, less the value of any services rendered to member(s) prior to cancellation and any processing fees, if applicable. If you wish to cancel within the 30 day period, you must submit a written cancellation request. Said refund shall be made within 30 days of receipt of the cancellation notice.

Cancellation requests must include the account holder's name and primary contact number and must be mailed to Hewlett Family Dental, 223 Midland Park, Shelbyville, KY 40065. You may also submit request by email to: drhewlett@bellsouth.net.

This plan is a discount membership program offered by the Office. Office is not a licensed insurer, health maintenance organization, or other underwriter of health care services. Savings are based upon the Office's normal fees. All listed or quoted prices are current prices and subject to change without notice. Discounts on professional services are not available where prohibited by law.