

## MY DENTIST IN MIAMI ADVANTAGE PLAN

Membership is active for twelve (12) months from the enrollment date and membership fees are non-refundable. My Dentist in Miami Advantage Plan is not an insurance plan. Discounts applied when services are provided to the patient. Discounts are not valid on any *sale* or *promotional items* or services. Discounts are not available on cosmetic or elective services. Program not valid with any other insurance and cannot be used for injuries covered under Worker's Compensation or any other similar insurance.

Annual Membership for an individual is \$ 399 Adults / \$ 299 Children (Age 12 and under) or \$ 599 Family (up to 3 family members living in the same household) each additional person \$ 175 Adult / \$ 150 Child. Includes all fee discounts as described below plus **TWO NO-CHARGE regular cleanings (D1120, D1110) per enrollment year in the absence of periodontal disease.**

Benefits received under Advantage Plan are as follow:

| <u>Treatment – ADA Code/ Description</u>          | <u>Discount</u> |
|---|-----------------|
| <b>DIAGNOSTIC</b> - D01000 – D0999                | 50 % Discount   |
| <b>PREVENTATIVE</b> - D1000 – D99                 | 50 % Discount   |
| <b>RESTORATIVE</b> - D2000 – D2999                | 25 % Discount   |
| <b>ENDODONTICS</b> - D3000 – D3999                | 25 % Discount   |
| <b>PERIODONTICS</b> - D4000 – D4999               | 25 % Discount   |
| <b>PROSTHODONTICS</b> - D5000 – D5999 (removable) | 15 % Discount   |
| <b>PROSTHODONTICS</b> - D6200 – D6999 (fixed)     | 15 % Discount   |
| <b>ORAL SURGERY</b> - D7000 – D7999               | 15 % Discount   |
| <b>ORTHODONTICS</b> - D8000 – D8999               | 10 % Discount   |

As the guarantor, I wish to enroll with a  INDIVIDUAL or  FAMILY - My Dentist in Miami Advantage Plan. I understand that this is not an insurance plan and cannot be used in conjunction with an insurance carrier. I understand that enrollment is effective \_\_\_\_\_ and expires within 12 months of the aforementioned date. *I further understand that the membership fee is non-refundable.*

Method of Payment:  MasterCard  Visa  American Express  Care Credit  Cash

---

Guarantor Signature

Date

## MY DENTIST IN MIAMI ADVANTAGE PLAN ENROLLMENT FORM

---

|                     |            |         |
|---------------------|------------|---------|
| Guarantor Last Name | First Name | Initial |
|---------------------|------------|---------|

---

|                 |      |       |     |
|-----------------|------|-------|-----|
| Mailing Address | City | State | Zip |
|-----------------|------|-------|-----|

---

|              |                        |               |
|--------------|------------------------|---------------|
| Phone Number | Social Security Number | Date of Birth |
|--------------|------------------------|---------------|

**Family Member #2**

---

|           |            |               |
|-----------|------------|---------------|
| Last Name | First Name | Date of Birth |
|-----------|------------|---------------|

**Family Member #3**

---

|           |            |               |
|-----------|------------|---------------|
| Last Name | First Name | Date of Birth |
|-----------|------------|---------------|

**Family Member #4**

---

|           |            |               |
|-----------|------------|---------------|
| Last Name | First Name | Date of Birth |
|-----------|------------|---------------|

**Family Member #5**

---

|           |            |               |
|-----------|------------|---------------|
| Last Name | First Name | Date of Birth |
|-----------|------------|---------------|

---

Guarantor Signature

Date