NO DENTAL INSURANCE?

“Give to every person more than you take from them”

LET US HELP YOU

Cherrington Dental
Savings Program

7500 West Lake Mead Blvd Ste 11
Las Vegas, Nevada 89128
T: (702) 735-5066  F: (702) 933-9061
W: www.cherringtondental.com
Now Accepting New Patients!

The Cherrington Dental Savings Program is designed to provide affordability and greater access to quality dental care.

The good news is that with your Savings Plan there are:

• No yearly maximums or deductibles
• No claim forms
• No pre-existing condition limitations
• No pre-authorization requirements
• Immediate eligibility (no waiting periods)

Coverage
You will not receive any membership card. Your plan’s effective date will be kept on file.

Your Savings

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$199.00***</td>
</tr>
<tr>
<td>Dual*</td>
<td>$379.00***</td>
</tr>
<tr>
<td>Family**</td>
<td>$689.00***</td>
</tr>
</tbody>
</table>

* The dual plan is for parent/child OR spouse/spouse

** The family plan includes children until age 24

*** For patients with periodontal treatment needs, the plan is the premium price plus $100

Program Exclusions and Limitations

This program is a discount plan, NOT a dental insurance plan and cannot be used:

• In conjunction with any other dental plan or discount plan
• For services or injuries covered under workman’s compensation
• For treatment which, in the sole opinion of the treating provider, lies outside the scope of their practice
• For any other dental office, medical office, or hospital
• For costs of dental care which may be covered under automobile or medical insurance
• All-on-4 cases
• Perio Maintenance is covered 4 times per year with $15 co-pays

Program Guidelines

• Full benefit premiums are paid prior to any discount being applied to treatment
• The benefits run a year to date from the initial purchase date
• Benefit premiums will be AUTOMATICALLY RENEWED each year on the effective date unless WRITTEN NOTIFICATION is received by our office
• No refunds of premiums will be issued for any reason. It is the participant’s responsibility to utilize plan benefits
Savings Program

Please Circle One: Single Plan Dual Plan Family Plan

Please PRINT clearly and answer all questions or indicate “not applicable”

Applicant Profile

Name:______________________________.
Social Security #____________________ Date of Birth____________________.
Mailing Address__________________________________________.
Street Address (if different from above)_____________________________________.
Home Phone_________________Cell Phone______________________.
Work Phone_________________Email Address______________________.
Driver’s license number________________________State__________.

Spouse’s Profile

Name:______________________________.
Social Security #____________________ Date of Birth____________________.
Mailing Address__________________________________________.
Street Address (if different from above)_____________________________________.
Home Phone_________________Cell Phone______________________.
Work Phone_________________Email Address______________________.
Driver’s license number________________________State__________.

Children

Name_________________________Age_____SS#______________________.
Name_________________________Age_____SS#______________________.
Name_________________________Age_____SS#______________________.
Name_________________________Age_____SS#______________________.
Thank you for taking advantage of our savings program. We are looking forward to providing you affordability and greater access to quality dental care. We gladly accept enrollment over the phone or you may mail this completed application with your credit card information to:

Cherrington Dental  
Attn: Cherrington Dental Savings Program  
7500 West Lake Mead Blvd Suite 11  
Las Vegas, Nevada 89128

Credit Card Information

Credit Card #_________________________Expiration Date___________.  
Billing Address and Zip Code____________________________.  
Security Code (on back)___________.

Visa   MasterCard
Please circle card type

I understand that by signing this form, my savings program will be automatically renewed each year on the same date, using the credit card listed above.

______________________________________________
Applicant's Authorized Signature                  Date