WEBB DENTISTRY

IN OFFICE
DENTAL
SAVINGS PLAN
•
2022

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Cost of Dental Savings Plan
Individual Coverage $375.00 – Yearly
Individual + 1 Coverage- $725.00 – Yearly
Dependents 25 & under - $300.00 – Yearly

Benefits Included

* Two Routine Exams
* Two Healthy Cleanings
* One Oral Cancer Screening
* One Topical Fluoride Application for Children up to age 16
* One Emergency Exam, X-ray and Oral Image
* Bitewing X-rays one time a year and Full Mouth X-rays as needed
* All eligible Dental Treatment Discounted 17% to 20% when paid in full at time of service

(This is not an insurance program)

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In-Office Dental Plan

Policies and Exclusions

Eligibility

- This plan is only good at Webb Dentistry.
- This is not a dental insurance plan.
- To be an independent member, you must be 18 or older.
- This plan cannot be combined with any other dental insurance.

Payments

- All payments are due at the time of service.
- Any service that are not paid in full at the time of service will be billed at our regular fees.
- All payments are nonrefundable.
- No refunds will be given if a member and/or spouse or children do not use the plan, relocate or obtain dental insurance.
- 12- month plan term effective form sign date to renewal date.

Exclusions

- Bleaching Trays and Kit
- Cosmetic dentistry including veneers, implants and full smile crowns are excluded.
- Plans and fees are subject to change yearly.
- Treatment initiated prior to enrollment is not eligible for fee reduction.
- Webb Dentistry reserves the right to discontinue this plan for any member at any time.
- Two no shows or cancellations without a 24 hour notice can lead to you being dropped from this plan without a refund.
- If you choose to extend your payment for treatment by paying through Care Credit, Lending Club the treatment savings are only 15%
- If you choose are paying through Visa, Master Card or American Express treatment savings are reduced to 17% .
- If you choose paying cash/check treatment savings are reduced to 20%.
- Sunbit Financial no savings.

Enrollment Application of the In-Office Dental Savings Plan

- Name: _____
- Address:_____
- _____
- DOB: _____ SS#:_____
- Phone: _____ email:_____
- Dependents: (if coverage) _____
- _____
- _____
- Enrollment Fee
- Effective Date_____ Renewal Date_____
- Member $ _____ Spouse $ _____ Dependent's $_____ Total $_____
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- I, _____ do hereby understand the policies and limitations of Webb Dentistry In –office dental plan.
- Benefits Included
- 2 routine Exams
- 2 healthy cleanings
- 1 oral cancer screening
- 1 topical fluoride Application for children up to age 16
- X-rays – Bitewings once a year and Full mouth every 3 to 5 years
- 1 emergency exam, xray, and oral image
- All eligible dental treatment 15 to 20% savings
- Signature _____ Date _____
- Witness _____ Date_____