

Discount Dental Plan

Offered by
Katsur Dental & Orthodontics

Membership Application

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Please Review These Important Terms and Conditions Prior to Enrolling in the Discount Dental Plan Offered by Katsur Dental & Orthodontics.

The Discount Dental Plan Offered by Katsur Dental & Orthodontics is NOT INSURANCE. Members pay their dental provider Katsur Dental & Orthodontics at the time of service. This discount dental plan may be duplicative of your dental insurance. The Discount Dental Plan Offered by Katsur Dental & Orthodontics cannot be combined with any other dental or medical insurance plan and does not coordinate benefits with any other dental or medical insurance plan. Members may be eligible for reduced cost or free programs provided by the government. Katsur Dental & Orthodontics has verified credentials of their dental professionals providing services but does not guarantee the quality of dental services or products. Complaints regarding professional services should be directed to the appropriate State dental licensing authority. Membership benefits are limited to the discounted fees as itemized in the Schedule of Fees provided to you. The Discount Dental Plan Offered by Katsur Dental & Orthodontics is valid only at Katsur Dental & Orthodontics offices. Services provided by dental specialists may not be available in all locations. Fees are subject to periodic change without prior notification.

A membership may be canceled within 30 days of its acceptance for a full refund of the initial enrollment fee. After membership has been in effect for 30 days, the Member may not cancel membership until the expiration date of the initial term of the membership. The membership of any Member may be revoked and canceled if such Member does not comply with the policies of Katsur Dental & Orthodontics, including by reason of failing to make prompt payment for any procedure, for failing to pay any cancellation fee for missing an appointment, for failing to pay any fee when due or for providing false or misleading information to Katsur Dental & Orthodontics. If such Member is part of a Family Plan, then Katsur Dental & Orthodontics shall have the right to revoke and cancel the membership of all Members of such family. Immediately upon any cancellation of membership, whether by the Member or by the Discount Dental Plan Offered by Katsur Dental & Orthodontics all benefits shall cease.

New Members are subject to acceptance by the Discount Dental Plan Offered by Katsur Dental & Orthodontics. The Discount Dental Plan Offered by Katsur Dental & Orthodontics may refuse to accept any new Member at its discretion for any reason not prohibited by law. For purposes of the discounted membership fee for additional family members, family members include spouses and children 18 years of age and younger living in the same household as the primary member. In the case of any dispute between the Member (and/or any additional family member) and the Discount Dental Plan Offered by Katsur Dental & Orthodontics which has not been resolved through negotiation between the parties, such dispute shall be settled and determined through arbitration in accordance with the Rules of Arbitration of the American Arbitration Association ("AAA"). Any arbitration pursuant to this agreement shall be held in Maricopa County, Arizona, and shall be conducted by a single arbitrator to be selected by other arbitrators, one of whom shall be selected by each party. The written decision of the arbitrator so selected shall be binding, final, and conclusive on the parties. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The fees and expenses of arbitration shall be part of the award. The prevailing party in any arbitration shall recover its expenses and costs including reasonable attorney's fees from the other party.

The undersigned Member(s) acknowledge(s) and agree(s) to the foregoing and a parent's signature below shall be on behalf of any minor children under 18 years of age covered by this Application.

Patient Signature _____ Patient Name _____

Date _____

First Name _____ MI _____ Last Name _____

Date of Birth of Applicant _____ Male/Female Residence or Work Telephone _____ Alternate Telephone _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip _____

Pay by Credit Card: Visa Mastercard Account # _____

Exp. Date _____ E Mail Address: _____

List of Household Members

First Name	Last Name	Date of Birth
_____	_____	____-____-____
_____	_____	____-____-____
_____	_____	____-____-____
_____	_____	____-____-____