CIRCADIAN MEMBERSHIP

Member Registration		
Name		
Last	First	Middle
Address		
Street		Apt#
City	State	Zip Code
Home Phone	**Work Phone**	**Cell Phone**
( )	( )	( )
Birth date / /	**Employer**	

List Covered Dependents	Birth Date	Relationship
1.		
2.		
3.		
4.		
5.		
6.		

Select Payment Method

1. ___ 12 Month Annual Payment
Valid for 12 months from day of enrollment

2. ___ Monthly Bank Draft
Voided check and state issued ID required
Additional $2 per month transaction fee
Account #

_____
Bank Name

_____

3. ___ Monthly Credit Card Draft
Credit Card and state issued ID required
Additional $2 per month transaction fee
Account #

_____
Expiration

Date_____

Circadian Dental Plan is an annual reduced fee dental plan that allows individuals and families to receive quality dental services from participating dental offices. Circadian Dental Plan is currently accepted by the following providers –

Alpenglow Dental – 801-561-8131
7430 South Creek Road 101
Sandy, Utah 84093

Alpenglow Dental – 801-878-1700
3672 West South Jordan Pkwy 104
South Jordan, Utah 84095

Alpenglow Dental – 801-397-5220
425 South Medical Drive 211
Bountiful, Utah 84010

Cost of Membership is as follows-

1 Member	$15.00 per month
2 Members	$27.00 per month
3+ Members	$39.00 per month

Benefits of enrollment in membership include exams, x-rays, and cleanings (up to 2 per year) at no cost. Any treatment received will be discounted 40%. Membership paid monthly will have an additional $2 per month transaction fee. After membership is activated to receive care simply call a participating office to schedule an appointment.

I understand the benefits, limitations, exclusions and requirements of the plan and I agree to the following: ***I will remain in the plan and pay membership fees for a minimum of 12 months.*** Payment of less than 12 month's membership fees may result in my being charged usual and customary fees for all services (including those already provided) and my being charged remaining month's fees in lump sum. ***Fees and co-pays for dental services are due as services are rendered.*** Fees for prosthodontic and cast restoration services are due at the preparation/ impression visit. Failure to comply may result in my being charged usual and customary fees for such services. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs. Coverage must be continuous. Missing monthly payments must be made up for interrupted coverage. Membership dues and processing fees are not refundable.

Signature (Required) _____

Date _____

Dental Limitations and Exclusions

1. Demonstrated non-compliance with recommended course of treatment.
2. Services which in the opinion of the attending dentist, are neither necessary nor recommended for the patients dental health.
3. Periodontics, prosthodontics, endodontics, orthodontics, oral surgery or pedodontics requiring the services of a non-participating dentist.
4. Services that cannot be preformed because of the general health, physical or psychological limitations of the patient.
5. Services requiring IV sedation or general anesthesia.