Complete This Form to Begin Coverage Today

Please List All Children You Wish to Enroll

1. Child’s First Name _______________________
   Middle Initial ______________      Son / Daughter
   Date of Birth __________________________

2. Child’s First Name _______________________
   Middle Initial ______________      Son / Daughter
   Date of Birth __________________________

3. Child’s First Name _______________________
   Middle Initial ______________      Son / Daughter
   Date of Birth __________________________

4. Child’s First Name _______________________
   Middle Initial ______________      Son / Daughter
   Date of Birth __________________________

Our Affordable Coverage Includes the Following Services at No Charge:

• Comprehensive Exam (once every 6 months)
• X-Rays (once every 12 months)
• Fluoride Treatment for Children (under the age of 18, once every 6 months)
• Cleaning (Prophylaxis) (once every 6 months)

Enroll Today!

Join Wai‘alae Dental Care’s In-House Premier Dental Coverage

• All Health Conditions Accepted!
• You Cannot Be Denied Coverage!
• No Deductibles!
• No Health Questions!
• You Cannot Be Singled Out for Rate Increases or Cancellations!

We are located on Wai‘alae Avenue, in between Palolo & 6th avenues.

Low-Cost Dental Coverage
As Low as $17/mo.

Affordable Dental Coverage
For You & Your Entire Family

As Low as $17/mo.

We’re Making Excellence in Dentistry Affordable for You!

3270 Wai‘alae Avenue, Honolulu, HI 96816
808-732-4377
WaialaeDentalCare.com
Affordable Dental Coverage for the Whole Family!

Now you can join our low-cost dental coverage for a nominal membership fee. Our coverage entitles you to preventive dental care at no cost! Corrective services are available for small co-payments that are far less than the usual, customary fees. Our professional staff is qualified to care for all of your dental needs!

To enroll, simply fill out the enclosed enrollment form & return it with your check, money order or credit card information. Please make your check or money order payable to Wai'alae Dental Care.

Low-Cost Dental Coverage
$197/yr. per person

Preventive Dentistry

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Payment “Basic Care”</th>
<th>Regular Fees as High as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>No Charge</td>
<td>$88</td>
</tr>
<tr>
<td>X-Rays (every 12 months)</td>
<td>No Charge</td>
<td>$143</td>
</tr>
<tr>
<td>Adult Cleaning (every 6 months)</td>
<td>No Charge</td>
<td>$150</td>
</tr>
<tr>
<td>Children’s Cleaning (every 6 months)</td>
<td>No Charge</td>
<td>$105</td>
</tr>
<tr>
<td>Fluoride Treatment</td>
<td>$20 + Tax</td>
<td>$75</td>
</tr>
</tbody>
</table>

for Children (every 6 months)

Restorative Dentistry

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Payment “Basic Care”</th>
<th>Regular Fees as High as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightguard</td>
<td>$400</td>
<td>$550</td>
</tr>
<tr>
<td>Invisalign®</td>
<td>$5,795</td>
<td>$7,244</td>
</tr>
<tr>
<td>1-Surface Filling</td>
<td>$149</td>
<td>$231</td>
</tr>
<tr>
<td>Crown</td>
<td>$896</td>
<td>$1,210</td>
</tr>
<tr>
<td>Root Canal</td>
<td>$728</td>
<td>$956</td>
</tr>
<tr>
<td>Denture–Top</td>
<td>$1,075</td>
<td>$1,458</td>
</tr>
<tr>
<td>Extraction</td>
<td>$218</td>
<td>$264</td>
</tr>
<tr>
<td>Implant</td>
<td>$3,500</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

Please Inquire About Services Not Listed Here!

Orthodontics

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Payment “Basic Care”</th>
<th>Regular Fees as High as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightguard</td>
<td>$400</td>
<td>$550</td>
</tr>
<tr>
<td>Invisalign®</td>
<td>$5,795</td>
<td>$7,244</td>
</tr>
</tbody>
</table>

Please complete this form to begin coverage today!

First Name ____________________________ Last Name ____________________________
Middle Initial ________________________ Female / Male
Home Address ____________________________________________
City __________________________________ State ______ Zip ______
Phone __________________________________ Email __________________________________
Date of Birth _____/_____/_____
Spouse First Name ____________________________ Last Name ____________________________
Middle Initial ________________________ Female / Male
Date of Birth _____/_____/_____
Enrollment Period _______________ to _______________
Signature (member & spouse) __________________________________ Date ___________
________________________________ Date ___________
American Express / Discover / MasterCard / Visa
Card Number __________________________________ Expiration Date __________
Expiration Date __________

[ ] Make your check or money order payable to Wai'alae Dental Care.

3270 Wai'alae Avenue, Honolulu, HI 96816
808-732-4377
WaialaeDentalCare.com

Patients agree that Wai'alae Dental Care fees stated must be paid at the time services are rendered. Any service not paid for at the time of service will be billed at usual & customary fees. Coverage fees are valid only when paid at the time of enrollment. All family members must reside in the same household. This is not an insurance product. Membership renews annually on the day & month of initial enrollment. Membership renews automatically unless member formally requests otherwise in advance.