DELTA DENTAL®

Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800-914-3566
www.nedelta.com

HOW TO COMPLETE THE CONTRACT APPLICATION FOR INDIVIDUAL DENTAL BENEFITS

Review and choose one of the nine plan options defined in the individual dental benefit brochure. Complete, sign, and mail your Contract Application for Individual Dental Benefits along with your premium payment to the address indicated on the application.

The following are tips on completing your application:

- The application needs to be filled out and signed by an adult applicant.
- Your requested effective date must be the first day of the month you choose to begin your coverage. If no date is indicated, your effective date will be the first day of the month following receipt of your completed application and first month's premium payment.
- Children may only be enrolled if at least one parent or guardian is enrolled.
- Premium Calculation:
    1) Indicate the enrollment type:
       Subscriber Only (Applicant).
       Subscriber/Spouse/Civil Union Partner **or** Subscriber/Child.
       Subscriber/Family **or** Subscriber/Children.
    2) Enter the monthly rate that corresponds with the option you selected.
- You have two payment options. Select the payment method that best suits your needs. If choosing the Optional Billing and Payment Method, please fill out the Payment Option Form included with your application, include a voided check from that account, as well as a binder check for all premiums due.
- Let us know if you or your spouse will be coming from another Northeast Delta Dental plan. The adult applicant must sign and date this section.
- Please leave the section that states **For Northeast Delta Dental Use Only** blank.
- Under Benefit Structures and Option selection, indicate which plan option you have selected by checking the appropriate option number box.
- Producer Information: If you are working with a licensed producer to apply for this coverage, have the producer fill out this section. Leave this section blank if no producer is involved.

Should you need additional assistance after reviewing this information, please contact the Northeast Delta Dental Marketing Department by calling 800-914-3566.

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DELTA DENTAL PLAN OF VERMONT, INC.
CONTRACT APPLICATION FOR INDIVIDUAL DENTAL BENEFITS

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

Applicant may only apply if not covered under another dental plan.

Last Name: ______________ **First Name:** ______________ **SS#:** ______________

Physical Address: ______________ **City:** ______________ **State:** ______ **ZIP:** ______

Mailing Address: ______________ **City:** ______________ **State:** ______ **ZIP:** ______

Date of Birth (mm/dd/yyyy): ______________ **Gender:** ______ **Telephone:** ( ) ______________

E-Mail: ______________ **Requested Effective Date:** ______________
(Must be 1st of the month)

Complete the following segment *only* if enrolling family members. If you are enrolling some, but not all, of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME	FIRST NAME	DATE OF BIRTH mm/dd/yyyy	GENDER M/F	RELATION TO SUBSCRIBER	*CHECK IF DEPENDENT IS INCAPACITATED

***NOTE: Legal documentation is required.**

PREMIUM CALCULATION

Select Enrollment Type	Subscriber Only: ☐	Subscriber/Spouse/ Civil Union Partner **or** Subscriber/Child: ☐	Subscriber/Family **or** Subscriber/Children: ☐
Enter Monthly Rate from Option Selection	$ ______	$ ______	$ ______

(First month's premium is due with contract application)

BILLING AND PAYMENT METHOD

☐ **Standard Billing and Payment Method:** Monthly bill payable with check or money order.
☐ **Optional Billing and Payment Method:** See Payment Option Form.

Does this coverage replace another **Northeast Delta Dental plan**? ☐ Yes ☐ No If yes, Subscriber ID # ______________

I (and my dependents if applicable) reside in the State of Vermont, and are not currently enrolled in another dental plan.

Name (please print): ______________

Signature: ______________

Date: ______________

Delta Dental Plan of Vermont, Inc.

By: ______________

Name: Thomas Raffio

Title: President & CEO

Date: ______________

FOR NORTHEAST DELTA DENTAL USE ONLY

Group Number: ______________ Option Selection: ______________ Mkt: ______________

Effective Date: ______________ Anniversary Date: ______________ BA: ______________

VALID JULY 2011 - JUNE 2012

BENEFIT STRUCTURES AND OPTION SELECTION

Benefit percentages shown are based upon the actual charge submitted to a maximum of the Participating Dentist's approved fees, or Delta Dental's allowance for Non-Participating Dentists.

Make Option Selection ➡ Option Number:	☐ 1[1]	☐ 2	☐ 3	☐ 4[1]	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9
Diagnostic and Preventive Coverage A	100%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Coverage B	80%	80%	80%	60%	60%	60%	60%	60%	60%
Major Coverage C	50%	50%	50%	50%	50%	50%	No Coverage	No Coverage	No Coverage
Lifetime Deductible Per Person/Family (applies to Basic (Coverage B) and Major (Coverage C) services)	$100/$300	$100/$300	$100/$300	$75/$225	$75/$225	$75/$225	$50/$150	$50/$150	$50/$150
Diagnostic and Preventive (Coverage A); Basic (Coverage B); Major (Coverage C) Calendar Year Maximum Per Person	$2,000	$1,500	$1,000	$2,000	$1,500	$1,000	$1,500	$1,000	$750
Orthodontics Coverage D	50%	50%	50%	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
Orthodontic Lifetime Maximum Per Person	$2,000	$1,500	$1,000	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage

WAITING PERIODS

Benefits are effective on the first day of the month following the number of months (shown below) of continuing coverage.

	1	2	3	4	5	6	7	8	9
Diagnostic and Preventive Coverage A	None	None	None	None	None	None	None	None	None
Basic Coverage B	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months
Major Coverage C	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	N/A	N/A	N/A
Orthodontics Coverage D	24 Months	24 Months	24 Months	N/A	N/A	N/A	N/A	N/A	N/A

MONTHLY RATES

Rates are guaranteed for one year from the initial effective date of this contract for individuals effective July 2011 through June 2012.

	1	2	3	4	5	6	7	8	9
Subscriber Only	74.72	72.45	69.84	62.80	61.51	59.61	48.51	47.52	46.49
Subscriber/Spouse/ Civil Union Partner **or** Subscriber/Child	131.10	124.37	118.45	104.71	102.48	99.35	81.18	78.79	76.66
Subscriber/Family **or** Subscriber/Children	230.26	214.26	201.66	168.63	165.18	160.92	146.11	143.93	142.27

[1] **Carryover Benefit** - Options 1 and 4 include a carryover benefit feature that can extend your annual benefit.

PRODUCER INFORMATION – This section to be filled out by a licensed insurance producer only, if applicable.

Producer Name:	**Tax ID Number:** (for IRS/1099 purposes)
Agency Name:	**Commission Paid To:** ☐ Producer ☐ Agency
Street Address:	**Contract Sent To:** ☐ Producer ☐ Subscriber
City:	
State: **Zip:**	**E-mail Address:**
Telephone: **Ext.:**	**Fax:**

Producer Signature: X

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Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire, Inc.
Delta Dental Plan of Vermont, Inc.

PAYMENT OPTION FORM

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

Applicant Name:			
Group Number: **To be assigned by Northeast Delta Dental**			
Effective Date:			
The applicant hereby authorizes Northeast Delta Dental to initiate debit entries against the checking account indicated below and further authorizes the bank named below (BANK) to debit the same to such account.			
Bank Name:			
City:		State:	
Checking Account Number: **Type of account must be checking**			
Transit/ABA Number: **9-digit number**			
I would like to receive a copy of my bill: ______ YES ______ NO			

It is your responsibility to reconcile eligibility/status changes to the withdrawn amount. NOTE: Retroactive billing adjustments are not allowed past three months.

The debit entry will be initiated within the first five business days of each month and shall not exceed Northeast Delta Dental's billed amount.

This authority is to remain in full force and effect until Northeast Delta Dental and BANK have received written notification from the applicant of its termination in such time and in such manner as to afford Northeast Delta Dental and BANK a reasonable opportunity to act on it.

Authorized Signature:		Date:	
Please Print or Type Name:			

NOTE: PLEASE ATTACH A VOIDED CHECK FROM THE ACCOUNT TO BE USED AND A BINDER CHECK FOR THE INITIAL PREMIUM DUE.

Form No. POF 060211