DELTA DENTAL

800-537-1715 Corporate • 603-223-1230 Eligiblity • 603-223-1252 Eligibility Fax

Delta Dental Plan of Vermont

DENTAL ENROLLMENT / CHANGE FORM

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

Please send form to:
Northeast Delta Dental
PO Box 2002
Concord, NH 03302-2002
Web site: www.nedelta.com

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	GENDER ☐M ☐F	DATE OF BIRTH (MM-DD-YYYY)
				– –

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED / CIVIL UNION PARTNER ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

E-MAIL

2. GROUP INFORMATION

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP

GROUP NUMBER	SUBLOCATION NUMBER	DIVISION	MISC. INFO (I.e. STORE LOC)

EFFECTIVE DATE (MM-DD-YYYY)	EMPLOYEE DATE OF HIRE (MM-DD-YYYY)	EMPLOYEE DATE OF REHIRE (MM-DD-YYYY)
– –	– –	– –

3. REASON FOR ENROLLMENT/CHANGE:

EXACT DATE OF STATUS CHANGE – – (MM-DD-YYYY) _____

ADD:
- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ COBRA Due to:
- ☐ Marriage/Civil union
- ☐ Birth ☐ Other:
- ☐ Adoption*
- ☐ Employment change for spouse/civil union partner
- ☐ Part-time to full-time employment status

DELETE:
- ☐ Annual open enrollment
- ☐ Employment change for spouse/civil union partner
- ☐ Full-time to part-time employement status
- ☐ Divorce/Termination of a civil union
- ☐ Deceased
- ☐ No longer dependent for IRS purposes
- ☐ Retirement
- ☐ Other_____

MISCELLANEOUS CHANGE:
- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation: _____
- ☐ Address change
- ☐ Other: _____

COVERAGE LEVEL REQUESTED
☐ Employee Only ☐ Employee & Spouse/Civil union partner ☐ Employee & Child ☐ Employee & Children ☐ Family

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

Last Name (If Different)	First Name	M.I.	Relationship To Subscriber	Date Of Birth Mo	Day	Yr	Check If Dependent under age 26	Check If Dependent Is Incapacitated[1]

[1]Legal documentation may be required.

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse/civil union partner, or any dependent be covered under any other group plan while this policy is in effect? ☐ Yes ☐ No

Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No **If yes to either question, complete the following:**

DENTAL INSURANCE COMPANY	POLICYHOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE (MM-DD-YYYY)
		– –

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. **By signing below I hereby accept coverage.**

This policy provides dental benefits only. Review your policy carefully.

SIGNATURE (REQUIRED): _____ DATE: _____

Please retain a copy for your records

DELTA DENTAL

This chart represents the level of coverage for services performed by dentists who participate in the Delta Dental Premier network. Employees and their eligible dependents are free to visit *any* dentist, participating or nonparticipating. Visit our Web site at *www.nedelta.com* for an updated list of participating dentists. Your Northeast Delta Dental program includes all of the following coverage categories. This chart is provided for summary purposes only; certain benefit limitations may apply. Please refer to your benefit booklet for complete benefit information. In the event of a conflict or discrepancy between the chart and either the group contract or the benefit booklet, the contract or benefit booklet will prevail.

Engineers Construction, Inc.
#8986-0100

Diagnostic/Preventive Coverage A	Basic Coverage B	Major Coverage C	Orthodontics Coverage D
Deductible: None	**Lifetime Deductible:** $100 Per Person ($300 Per Family)		**Deductible:** None
Waiting Period: None	**Waiting Period:** 6 Months	**Waiting Period:** 12 Months	**Waiting Period:** 24 Months
Covered at *100%	**Covered at *80%**	**Covered at *50%**	**Covered at *50%**
Diagnostic: Evaluations twice in a 12-month period X-rays (Complete series or panoramic film) once in a 3-year period Bitewing x-rays once in a 12-month period X-rays of individual teeth as necessary Oral cancer screening once in a 12-month period **Preventive:** Cleanings four in a 12-month period Fluoride twice in a 12-month period to age 19 Space maintainers to age 16 Sealant application to permanent molars, once in a three year period per tooth for children to age 19	**Restorative:** Amalgam (silver) fillings Composite (white) fillings for anterior teeth only **Oral Surgery:** Surgical and routine extractions **Endodontics:** Root canal therapy **Periodontics:** Periodontal maintenance (cleaning) *Four cleanings are covered in a 12-month period; this can be routine (Coverage A) or Periodontal (Coverage B), in any combination.* Treatment of gum disease Clinical Crown Lengthening once per lifetime per site **Denture Repair:** Repair of a removable denture to its original condition **Emergency Palliative Treatment**	**Prosthodontics:** Removable and fixed partial dentures (bridge); complete dentures Rebase and reline (dentures) Crowns Onlays Implants	**Orthodontics:** Correction of crooked teeth for adults and children
Calendar Year Maximum: $1,000 per person (Coverages A, B and C combined)			**Orthodontic Lifetime Maximum:** $1,000 Per Person

*** 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 nonparticipating dentists.**