



## 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/civil union partner 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 1-800-537-1715.



**DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.  
CONTRACT APPLICATION  
FOR INDIVIDUAL DENTAL BENEFITS**

Northeast Delta Dental  
One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
800-537-1715  
www.nedelta.com

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

**Applicant and dependents 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 a month)

**Complete the following segment *only* if enrolling your spouse/civil union partner or other eligible dependents. 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 CHILD IS LESS THAN 26 YEARS OF AGE	**CHECK IF DEPENDENT CHLD IS INCAPACITATED

\*The Dependent child must be unmarried; either a NH resident or a student; and if over 18 and not a student, not covered by any other plan. \*\*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.

**The policy provides dental benefits only. Review your policy carefully.**

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 New Hampshire, and are not currently enrolled in another dental plan.

**Delta Dental Plan of New Hampshire, Inc.**

Name (please print): \_\_\_\_\_

By: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: **Thomas Raffio**

Date: \_\_\_\_\_

Title: **President & CEO**

Date: \_\_\_\_\_

**FOR NORTHEAST DELTA DENTAL USE ONLY**

Group Number: \_\_\_\_\_ Option Selection: \_\_\_\_\_ Mkt: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Anniversary Date: \_\_\_\_\_ BA: \_\_\_\_\_

### 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:	<input type="checkbox"/> 1 <sup>1</sup>	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4 <sup>1</sup>	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
<b>Diagnostic and Preventive Coverage A</b>	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>Basic Coverage B</b>	80%	80%	80%	60%	60%	60%	60%	60%	60%
<b>Major Coverage C</b>	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
<b>Orthodontics Coverage D</b>	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.

<b>Diagnostic and Preventive Coverage A</b>	None	None	None	None	None	None	None	None	None
<b>Basic Coverage B</b>	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months
<b>Major Coverage C</b>	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	N/A	N/A	N/A
<b>Orthodontics Coverage D</b>	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 2010 through June 2011.

Subscriber Only	\$74.24	\$72.30	\$69.52	\$61.83	\$60.62	\$58.86	\$51.89	\$50.63	\$49.50
Subscriber/Spouse/ Civil Union Partner <u>or</u> Subscriber/Child	\$129.56	\$123.40	\$119.17	\$103.00	\$100.91	\$97.86	\$86.55	\$83.88	\$81.54
Subscriber/Family <u>or</u> Subscriber/Children	\$225.48	\$210.83	\$197.74	\$165.75	\$162.62	\$158.51	\$155.54	\$153.09	\$150.83

<sup>1</sup> **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.

<b>Producer Name:</b> Robert Ellis	<b>Tax ID Number:</b> 37-1501115 <small>(for IRS/1099 purposes)</small>
<b>Agency Name:</b> Stonebridge Benefits Group, LLC	<b>Commission Paid To:</b> <input type="checkbox"/> Producer <input checked="" type="checkbox"/> Agency
<b>Street Address:</b> 2 Executive Park Dr.	<b>Contract Sent To:</b> <input type="checkbox"/> Producer <input checked="" type="checkbox"/> Subscriber
<b>City:</b> Bedford	
<b>State:</b> nh <b>Zip:</b> 03110	<b>E-mail Address:</b> bob@stonebridgebenefits.com
<b>Telephone:</b> 603 289 8683 <b>Ext.:</b>	<b>Fax:</b> 603 218 6319
<b>Producer Signature:</b> <input checked="" type="checkbox"/> Robert Ellis	



Northeast Delta Dental  
 One Delta Drive  
 PO Box 2002  
 Concord, NH 03302-2002  
 800-537-1715  
 www.nedelta.com

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: <b>To be assigned by Northeast Delta Dental</b>			
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: <b>Type of account must be checking</b>			
Transit/ABA Number: <b>9-digit number</b>			
I would like to receive a copy of my bill: <input type="checkbox"/> YES <input type="checkbox"/> 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.**