



## Application To Join The New Hampshire Medical Society Delta Dental Plan

Completion of this Application makes the Employer a Participating Member Employer subject to the terms and conditions of the contract between New Hampshire Medical Society and Northeast Delta Dental. This includes being a member in good standing.

EMPLOYER: \_\_\_\_\_ EFFECTIVE DATE OF PROGRAM: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_, NH ZIP: \_\_\_\_\_

TELEPHONE: (603) \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

MEDICAL CARRIER: \_\_\_\_\_ GROUP CONTACT: \_\_\_\_\_

PRIOR DENTAL COVERAGE? [ ] YES [ ] NO IF YES, CARRIER NAME: \_\_\_\_\_  
(Attach copy of prior dental plan benefit booklet)

	<b>CHECK ONE ONLY: Option 1 [ ]</b>	<b>Option 3 [ ]</b>	<b>Option 5 [ ]</b>	<b>Option 6 [ ]</b>	<b>Option 8 [ ]</b>
Coverage A .....	100%	100%	100%	100%	100%
Coverage B (After a 6-month waiting period) .....	80%	80%	60%	60%	60%
Coverage C (After a 12-month waiting period) .....	50%	50%	50%	50%	N/A
Coverage D (After a 24-month waiting period) .....	50%	50%	N/A	N/A	N/A
Lifetime Deductible Per Person/Family .....	\$100/\$300	\$100/\$300	\$75/\$225	\$75/\$225	\$50/\$150
<b>Calendar</b> Year Maximum for Coverages A, B, C .....	\$2,000	\$1,000	\$1,500	\$1,000	\$1,000
Separate Lifetime Maximum For Coverage D (per child and adult) ...	\$2,000	\$1,000	N/A	N/A	N/A

Eligibility (Probationary) Period: First day of the month following \_\_\_\_\_

<b>Option 1 Group #3981</b>	# Enrolled	Monthly Premium
One Person (Single):	\$59.10 X _____	= \$ _____
Two Persons:	\$101.50 X _____	= \$ _____
Three or More Persons (Family):	\$181.50 X _____	= \$ _____
Total First Month's Premium Due		\$ _____ (Include with Application)

<b>Option 3 Group #3983</b>	# Enrolled	Monthly Premium
One Person (Single):	\$55.60 X _____	= \$ _____
Two Persons:	\$94.10 X _____	= \$ _____
Three or More Persons (Family):	\$159.15 X _____	= \$ _____
Total First Month's Premium Due		\$ _____ (Include with Application)

<b>Option 5 Group #3985</b>	# Enrolled	Monthly Premium
One Person (Single):	\$48.45 X _____	= \$ _____
Two Persons:	\$81.05 X _____	= \$ _____
Three or More Persons (Family):	\$128.75 X _____	= \$ _____
Total First Month's Premium Due		\$ _____ (Include with Application)

<b>Option 6 Group #3986</b>	# Enrolled	Monthly Premium
One Person (Single):	\$47.05 X _____	= \$ _____
Two Persons:	\$78.70 X _____	= \$ _____
Three or More Persons (Family):	\$125.30 X _____	= \$ _____
Total First Month's Premium Due		\$ _____ (Include with Application)

<b>Option 8 Group #3988</b>	# Enrolled	Monthly Premium
One Person (Single):	\$40.50 X _____	= \$ _____
Two Persons:	\$68.40 X _____	= \$ _____
Three or More Persons (Family):	\$119.15 X _____	= \$ _____
Total First Month's Premium Due		\$ _____ (Include with Application)

**Above rates are guaranteed through May 31, 2009. Annual open enrollment effective June 1st each year.**  
**Make checks payable to: Northeast Delta Dental.**  
**All applications and correspondence should be directed to New England Employee Benefits Co., 15 Chenell Drive, Concord, NH 03301.**  
**For inquiries, please contact NEEBCO: Phone: 603-228-1133, Fax: 603-225-1960, e-mail: NHMS@neebco.com.**

\_\_\_\_\_  
Group Representative Signature Title Date

### Delta/NEEBCO Only

Delta Group # - \_\_\_\_\_ NHMS Sublocation # - \_\_\_\_\_

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