DELTA DENTAL

HADDON TOWNSHIP BOARD OF EDUCATION
GROUP # 7131-01
Delta Dental Premier®/Advantage Program

Preventive & Diagnostic * Exams, Cleanings & Bitewing X-rays each (twice in a calendar year) * Fluoride Treatment (children to age 19)	90%
Remaining Basic * Fillings, Extractions * Endodontics (root canal) * Periodontics, Oral Surgery * Sealants * Repair of Dentures	60%
Crowns * Crowns, Gold Restorations (over natural teeth)	60%
Prosthodontics * Bridgework * Full & Partial Dentures	50%
Calendar Year Maximum (per patient)	$1,000
Calendar Year Deductible * Per Person * Family Aggregate Deductible	N/A N/A
Orthodontic Benefits, full comprehensive treatment (Adult & Child) * Lifetime Maximum (per patient)	50% $800

Delta Dental of New Jersey has over 248,000 Delta Dental Premier participating dentists, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. Maximum benefit may be derived by utilizing the services of a participating dentist.

Advantage Program has a network of more than 6,000 dentists, all of whom are also in our Delta Dental Premier network. Advantage Program dentists have agreed to accept fees for services rendered to Advantage Program patients, which may be lower than their fees under our Delta Dental Premier program. Out-of-Advantage Program network payments are based on a scheduled table.

Combining the two programs, the Advantage Program offers those members choosing Advantage Program dentists the possibility of further reducing out-of-pocket expenses. Out-of-network benefits are based on the Delta Dental Premier program.

Visit your own dentist. If you do not have a dentist, there is a directory available with your plan administrator listing participating dentists. You may call **1-800-DELTA-OK** and a list of participating dentists located in your area will be mailed directly to your home or you may access our Website at www.deltadentalnj.com.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Social Security number. Your dependents, if covered, should give YOUR SOCIAL SECURITY NUMBER.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. and Friday, 8:00 a.m. to 5:00 p.m., at 1-800-452-9310.

This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview.

U&A _____

DELTA DENTAL

Enrollment/Change Request

Employer Group Information - To be completed by Employer

Group Name	Group Number	Sublocation/Store location
_____	_____	_____/_____

(A) Type of Activity - To Be Completed by Employer. Refer to instructions on back before completing this form. Print clearly.

1. Enrollment ( ) New Enrollee / Subscriber **Effective Date ___/___/___** **Date of Hire ___/___/___**

2. Change - Check all that apply	Date of Event	Reason
( ) Add Spouse	__/__/__	_____
( ) Add Domestic Partner	__/__/__	_____
( ) Add Dependent Child	__/__/__	_____
( ) Name Change	__/__/__	_____
( ) Change Plan	__/__/__	_____
( ) Other	__/__/__	_____
( ) Add/Change Office ID Numbers	__/__/__	_____

3. Remove or Terminate - Check all that apply	Effective Date	Reason
( ) Remove Spouse*	__/__/__	_____
( ) Remove Domestic Partner*	__/__/__	_____
( ) Remove Dependent Child*	__/__/__	_____
( ) Employee Withdrawal/Termination	__/__/__	_____

NOTE: Employee must be enrolled for spouse/dependents(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.

~~Coverage for: ( ) Employee ( ) Dependents~~

Length of Continuation: ( ) 12 months ( ) 18 months ( ) 29 months ( ) 36 months ( ) Total Disability* Attach proof of total disability

Date of Loss of Coverage: __/__/__ Date of Qualifying Event: __/__/__

Billing: ( ) Home ( ) Group

(B) Employee Information - Complete Sections (B-G)

Last name, First name, MI _____ Social Security Number _____ Home Telephone _____

E-mail Address _____ Home Address _____ Apt # ____ City, State _____ Zip Code _____

Employer Name _____ Work Telephone _____ Work Address _____

City, State _____ Zip Code _____ Date of Employment __/__/__ Hours Worked per week _____

(C) Plan Option - Your selection must be offered by your Employer Check one: ( ) Delta Dental Premier® ( ) Delta Dental PPO™ ( ) Advantage Program ( ) Delta Dental PPO plus Premier ( ) DeltaCare®

(D) Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. (Attach proof if full-time post-secondary student. Attach proof of disability.)

	(A) Add (C) Change (R) Remove	Last Name First Name, MI	Sex M F	Birthdate MM/DD/YYYY	Social Security Number	Other Health Coverage	Previous Coverage Check if Yes
Employee	_____	_____	____	__/__/____	_____	_____	_____
Domestic Partner (If Coverage offered)	_____	_____	____	__/__/____	_____	_____	_____
Spouse	_____	_____	____	__/__/____	_____	_____	_____
Child	_____	_____	____	__/__/____	_____	_____	_____
Child	_____	_____	____	__/__/____	_____	_____	_____
Child	_____	_____	____	__/__/____	_____	_____	_____
Child	_____	_____	____	__/__/____	_____	_____	_____

(E) Other/Previous Insurance

Is your spouse employed? ( ) Yes ( ) No If "Yes", give name and address of your spouse's employer.

_____

If "Yes" to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

_____

If "Yes" to Previous Coverage, identify names(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

_____

(F) Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ( ) Yes ( ) No If "Yes", who and at what address?

_____

Explain the circumstances

_____

If any dependent's last name differs from yours, explain the circumstances.

_____

(G) Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature - Required _____ Date __/__/__ E-mail Address _____

(H) Employer Verification – To be Completed by Employer

Employer Signature - Required _____ Title _____ Date __/__/__

Instuctions

Employer

*Complete the Employer Group information in the upper left corner of the form.
*Section A - Type of Activity:Check boxes indicating reason(s) for submitting application.
*Complete Section (H) - Employer Verification (in the upper left corner of the second page)of the form.
*Employer must complete this section for all new enrollments, coverage changes and terminations.
*Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections (B-G)

Section (B) - Employee Information

- Complete all information in order for your application to be processed.

Section (C) Plan Option:

Check one Plan option box ( ) Delta Dental Premier ( ) Delta Dental PPO ( ) Delta Dental POS ( ) Delta Dental PPO Advantage Program ( ) DeltaCare
Select only an option offred by your employer.

Section (D) - Individuals Covered:

- Add/Change/Remove - Use "A","C",or"R" to indicate wqhether you are adding,changing or removing coverage for an individual
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex,Birthdate,and Social Security number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school **or its authorized representative** confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disibility.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section (F) - Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the dentist (if applicable). Indicate office ID number selection(s) on the form.

Section (E) - Pre-Existing Conditions Statement

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

Section (F) - Other/Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section (G) - Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section (H) - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section (I) - Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditons of Enrollment

Application Acknowledgment and Agreements

1 On behalf of myself and the dependents listed on the reverse side I agree to or with the following:
a) I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier, any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not afect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of the authorization if I request one.
d) I agree that a photocopy of this authorization is as valid as the original.

2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.

3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.

4 Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.

CC 07/09