



Application To Join The New Hampshire Motor Transport Association 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 Motor Transport Association 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)

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

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

Option 1

| | # Enrolled | Monthly Premium |
|--|------------------|-----------------|
| Monthly Rates: One Person(Single): | \$42.92 X _____ | = \$ _____ |
| Two Persons: | \$74.63 X _____ | = \$ _____ |
| Three or More Persons (Family): | \$129.50 X _____ | = \$ _____ |
| Total First Month's Premium Due | | \$ _____ |

Option 3

| | # Enrolled | Monthly Premium |
|--|------------------|-----------------|
| Monthly Rates: One Person(Single): | \$40.32 X _____ | = \$ _____ |
| Two Persons: | \$69.08 X _____ | = \$ _____ |
| Three or More Persons (Family): | \$112.96 X _____ | = \$ _____ |
| Total First Month's Premium Due | | \$ _____ |

Option 5

| | # Enrolled | Monthly Premium |
|--|-----------------|-----------------|
| Monthly Rates: One Person(Single): | \$34.77 X _____ | = \$ _____ |
| Two Persons: | \$59.18 X _____ | = \$ _____ |
| Three or More Persons (Family): | \$90.20 X _____ | = \$ _____ |
| Total First Month's Premium Due | | \$ _____ |

Option 8

| | # Enrolled | Monthly Premium |
|--|-----------------|-----------------|
| Monthly Rates: One Person(Single): | \$29.50 X _____ | = \$ _____ |
| Two Persons: | \$50.51 X _____ | = \$ _____ |
| Three or More Persons (Family): | \$84.54 X _____ | = \$ _____ |
| Total First Month's Premium Due | | \$ _____ |

Above rates are guaranteed through December 31, 2009. Annual open enrollment effective January 1st each year.

Make checks payable to: NHMTA.

All applications and correspondence should be directed to NHMTA, PO Box 3898, Concord, NH 03302-3898.

For inquiries, please contact NHMTA: Phone: 603-224-7337, Fax: 603-225-9361

Group Representative Signature

Title

Date

Delta/NHMTA Only

Delta Dental Group # - _____ NHMTA Store Location # - _____

Accepted By: _____