



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 6* []	Option 7* []
Coverage A	100%	100%	100%	100%	100%
Coverage B (After a 6-month waiting period)	80%	80%	60%	80%	80%
Coverage C (After a 12-month waiting period)	50%	50%	50%	50%	50%
Coverage D (After a 24-month waiting period)	50%	50%	N/A	50%	N/A
Lifetime Deductible Per Person/Family	\$100/\$300	\$100/\$300	\$75/\$225	\$100/\$300	\$100/\$300
Calendar Year Maximum for Coverages A, B, C	\$2,000	\$1,000	\$1,500	\$2,000	\$2,000
Separate Lifetime Maximum For Coverage D (per child and adult) ...	\$2,000	\$1,000	N/A	\$2,000	N/A

*Option 1 includes a Carryover Benefit feature; please refer to the Carryover Benefit flyer for more details.

*Options 6 and 7 exclude Diagnostic and Preventive Services from annual maximum.

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

Option 1

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$56.94	X _____	= \$ _____
Two Persons:	\$98.72	X _____	= \$ _____
Three or More Persons (Family):	\$171.99	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 3

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$53.47	X _____	= \$ _____
Two Persons:	\$91.38	X _____	= \$ _____
Three or More Persons (Family):	\$150.05	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 5

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$46.14	X _____	= \$ _____
Two Persons:	\$78.18	X _____	= \$ _____
Three or More Persons (Family):	\$119.81	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 6

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$51.44	X _____	= \$ _____
Two Persons:	\$89.16	X _____	= \$ _____
Three or More Persons (Family):	\$155.01	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 7

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$51.17	X _____	= \$ _____
Two Persons:	\$87.97	X _____	= \$ _____
Three or More Persons (Family):	\$147.11	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Above rates are guaranteed through December 31, 2017. 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: _____ NHMTA _____ Northeast Delta Dental