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

Monthly Rates:				# Enrolled	Monthly Premium
	One Person (Single):	$57.80	X	______	= $ ______
	Two Persons:	$100.20	X	______	= $ ______
	Three or More Persons (Family):	$174.57	X	______	= $ ______
	Total First Month's Premium Due				$ ______

Option 3

Monthly Rates:				# Enrolled	Monthly Premium
	One Person (Single):	$54.27	X	______	= $ ______
	Two Persons:	$92.75	X	______	= $ ______
	Three or More Persons (Family):	$152.30	X	______	= $ ______
	Total First Month's Premium Due				$ ______

Option 5

Monthly Rates:				# Enrolled	Monthly Premium
	One Person (Single):	$46.83	X	______	= $ ______
	Two Persons:	$79.35	X	______	= $ ______
	Three or More Persons (Family):	$121.60	X	______	= $ ______
	Total First Month's Premium Due				$ ______

Option 6

Monthly Rates:				# Enrolled	Monthly Premium
	One Person (Single):	$52.21	X	______	= $ ______
	Two Persons:	$90.50	X	______	= $ ______
	Three or More Persons (Family):	$157.34	X	______	= $ ______
	Total First Month's Premium Due				$ ______

Option 7

Monthly Rates:				# Enrolled	Monthly Premium
	One Person (Single):	$51.94	X	______	= $ ______
	Two Persons:	$89.29	X	______	= $ ______
	Three or More Persons (Family):	$149.32	X	______	= $ ______
	Total First Month's Premium Due				$ ______

Above rates are guaranteed through December 31, 2018. 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

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