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)

CHECK ONE ONLY:	Option 1 [ ]	Option 3 [ ]	Option 5 [ ]	Option 6 [ ]	Option 8 [ ]
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
Calendar 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 ____________________

Option 1 Group #3981

	Rate	# 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)

Option 3 Group #3983

	Rate	# 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)

Option 5 Group #3985

	Rate	# 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)

Option 6 Group #3986

	Rate	# 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)

Option 8 Group #3988

	Rate	# 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, 2008. 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: ____________________ NEEBCO ____________________ NEDD

Rev. 06-07