

Application Instructions for Northeast Delta Dental

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Jamie Stein, HealthNH.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to Jamie Stein, HealthNH.com along with the required first month's payment. *IMPORTANT - Original application and payment must be mailed to HealthNH.com.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Indicate enrollment type and proper premium amount.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Mail completed applications to:

Jamie Stein, HealthNH.com
Attn: New Enrollment
379 Amherst Street
Suite 340
Nashua, NH 03063

Jamie Stein, HealthNH.com will review your application for completeness and accuracy before we submit it to Northeast Delta Dental for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (603) 791-4585 or e-mail us at jamie@healthNH.com.



FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Jamie Stein, HealthNH.com

FAX# 1-866-730-4025

Dear Jamie Stein, HealthNH.com,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact Jamie Stein, HealthNH.com at (603) 791-4585 to verify receipt of my application.

****I understand that Jamie Stein, HealthNH.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to Jamie Stein, HealthNH.com. :

**Jamie Stein, HealthNH.com
Attn: New Enrollment
379 Amherst Street
Suite 340
Nashua, NH 03063**

I will send the original, signed application and premium payment, as soon as I have been contacted by Jamie Stein, HealthNH.com with confirmation that my application has been received by fax and reviewed for completeness.



**DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.
CONTRACT APPLICATION
FOR INDIVIDUAL DENTAL BENEFITS**

Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
800-537-1715
www.nedelta.com

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

Applicant and dependents may only apply if not covered under another dental plan.

Last Name: _____ First Name: _____ SS#: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth (mm/dd/yyyy): _____ Gender: _____ Telephone: () _____

E-Mail: _____ Requested Effective Date: _____

Complete the following segment *only* if enrolling family members. If you are enrolling some, but not all, of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME	FIRST NAME	DATE OF BIRTH mm/dd/yyyy	GENDER M/F	RELATION TO SUBSCRIBER	*CHECK IF DEPENDENT IS LESS THAN 26 YEARS OF AGE	**CHECK IF DEPENDENT IS INCAPACITATED

*Dependent must be unmarried; either a NH resident or a student; and if over 18 and not a student, not covered by any other plan. **Legal documentation is required.

PREMIUM CALCULATION

Select Enrollment Type

Subscriber Only:

Subscriber/Spouse or
Subscriber/Child:

Subscriber/Family or
Subscriber/Children:

Enter Monthly Rate

From Option Selection

\$ _____

\$ _____

\$ _____

(First month's premium is due with contract application)

BILLING AND PAYMENT METHOD

Standard Billing and Payment Method: Monthly bill payable with check or money order.

Optional Billing and Payment Method: See Payment Option Form.

Does this coverage replace another **Northeast Delta Dental plan**? Yes No If yes, Subscriber ID # _____

The policy provides dental benefits only. Review your policy carefully.

I and my dependents (if applicable) reside in the State of New Hampshire, and are not currently enrolled in another dental plan.

Applicant Signature _____ Date _____

FOR NORTHEAST DELTA DENTAL USE ONLY

Group Number: _____ Option Selection: _____ Mkt: _____

Effective Date: _____ Anniversary Date: _____ BA: _____

BENEFIT STRUCTURES AND OPTION SELECTION

Benefit percentages shown are based upon the actual charge submitted to a maximum of the Participating Dentist's approved fees, or Delta Dental's allowance for Non-Participating Dentists.

Make Option Selection → Option Number:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
Diagnostic and Preventive Coverage A	100%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Coverage B	80%	80%	80%	60%	60%	60%	60%	60%	60%
Major Coverage C	50%	50%	50%	50%	50%	50%	No Coverage	No Coverage	No Coverage
Lifetime Deductible Per Person/Family (applies to Basic (Coverage B) and Major (Coverage C) services)	\$100/\$300	\$100/\$300	\$100/\$300	\$75/\$225	\$75/\$225	\$75/\$225	\$50/\$150	\$50/\$150	\$50/\$150
Diagnostic and Preventive (Coverage A); Basic (Coverage B); Major (Coverage C) Calendar Year Maximum Per Person	\$2,000	\$1,500	\$1,000	\$2,000	\$1,500	\$1,000	\$1,500	\$1,000	\$750
Orthodontics Coverage D	50%	50%	50%	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
Orthodontic Lifetime Maximum Per Person	\$2,000	\$1,500	\$1,000	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage

WAITING PERIODS

Benefits are effective on the first day of the month following the number of months (shown below) of continuing coverage.

Diagnostic and Preventive Coverage A	None	None	None	None	None	None	None	None	None
Basic Coverage B	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months	6 Months
Major Coverage C	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	N/A	N/A	N/A
Orthodontics Coverage D	24 Months	24 Months	24 Months	N/A	N/A	N/A	N/A	N/A	N/A

MONTHLY RATES

Rates are guaranteed for one year from the initial effective date of this contract for individuals effective July 2007 through June 2008.

Subscriber Only	\$59.10	\$57.75	\$55.60	\$49.20	\$48.45	\$47.05	\$41.50	\$40.50	\$39.60
Subscriber/Spouse <u>or</u> Subscriber/Child	\$101.50	\$98.15	\$94.10	\$82.35	\$81.05	\$78.70	\$70.05	\$68.40	\$66.85
Subscriber/Family <u>or</u> Subscriber/Children	\$181.50	\$168.80	\$159.15	\$130.65	\$128.75	\$125.30	\$122.05	\$119.15	\$116.75

PRODUCER INFORMATION – This section to be filled out by a licensed insurance producer only, if applicable.

Producer Name: Jamie Stein	Tax ID Number: (for IRS/1099 purposes)
Agency Name: HealthNH.com Insurance Solutions	Commission Paid To: <input checked="" type="checkbox"/> Producer <input type="checkbox"/> Agency
Street Address: 379 Amherst St., Suite 340	Contract Sent To: <input type="checkbox"/> Producer <input checked="" type="checkbox"/> Subscriber
City: Nashua	
State: NH Zip: 03063	E-mail Address: jamie@healthNH.com
Telephone: (603) 791-4585 Ext.:	Fax: (866) 730-4025
Producer Signature: X	



Northeast Delta Dental
 One Delta Drive
 PO Box 2002
 Concord, NH 03302-2002
 800-537-1715
 www.nedelta.com

Delta Dental Plan of Maine
 Delta Dental Plan of New Hampshire, Inc.
 Delta Dental Plan of Vermont, Inc.

**PAYMENT OPTION FORM
 AUTHORIZATION AGREEMENT FOR
 AUTOMATIC WITHDRAWAL**

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

Applicant Name:			
Group Number: To be assigned by Northeast Delta Dental			
Effective Date:			
The applicant hereby authorizes Northeast Delta Dental to initiate debit entries against the checking account indicated below and further authorizes the bank named below (BANK) to debit the same to such account.			
Bank Name:			
City:		State:	
Checking Account Number: Type of account must be checking			
Transit/ABA Number: 9-digit number			
I would like to receive a copy of my bill: <input type="checkbox"/> YES <input type="checkbox"/> NO			

It is your responsibility to reconcile eligibility/status changes to the withdrawn amount. NOTE: Retroactive billing adjustments are not allowed past three months.

The debit entry will be initiated within the first five business days of each month and shall not exceed Northeast Delta Dental's billed amount.

This authority is to remain in full force and effect until Northeast Delta Dental and BANK have received written notification from the applicant of its termination in such time and in such manner as to afford Northeast Delta Dental and BANK a reasonable opportunity to act on it.

Authorized Signature:		Date:	
Please Print or Type Name:			

NOTE: PLEASE ATTACH A VOIDED CHECK FROM THE ACCOUNT TO BE USED.