

Delta Dental

Enrollment/ Status Change Form <u>Dependent Coverage</u>

New Enrollment
Add Dependent(s)
Drop Dependent(s

Read the entire document. Print the first page of this document to complete and bring with you for your hiring appointment. Save the remaining pages for your records. Employee's Name First Middle Initial Last Address City State Zip Code Social Security Number ___ - __ - ___ - ___ - ___ ___ Date of Birth ____ / ____ / ____ ☐ Male ☐ Female Hire Date ___ / ___ / ____ School **Coverage Status Desired:** _____ \$35.82 per month **Spouse Only** ______ \$34.24 per month One or More Children Spouse & Children ____ \$55.72 per month First Name MI Last Name Date of Birth Social Security Number Spouse Child Child Child Child Child Child I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected. I authorize the payroll reductions to be a Section 125 Before-Tax Contribution. Changes in the cafeteria plan elections can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status; change in number of dependents; termination or commencement of employment). Signature Date

Delta Dental Premier

Traditional Dental Option



Dental Benefits for Hopkins County Board of Education

This is not a contract. It is a partial list of benefits and services. For complete details refer to your certificate,

Deductible

(Each Benefit Period)

\$25 individual

Maximum Benefits

(Per Covered Person each contract year

\$2,000

September 1 through August 31)

Diagnostic and Preventive Services

◆ Oral examination (limited to 2 per calendar year)

◆ Palliative emergency treatment

Periapical, bitewing, panoramic or complete series x-ray

◆ Topical fluoride application (up to age 19)

♦ Routine cleanings

♦ Sealants (up to age 16)

Minor Services

♦ Routine fillings

♦ Simple extractions

Root canal therapy

♦ Simple denture repair

Oral surgery

Space maintainers (up to age 11)

Inlays or crowns

Major Services

Prosthetic services (bridges, dentures and partials)

♦ Periodontic services

Reimbursement Amount

100% of the Allowable Amount

No deductible.

Reimbursement Amount

80% of the Allowable Amount

Subject to the \$25 individual deductible

Reimbursement Amount

50% of the Allowable Amount

Subject to the \$25 individual deductible

Please note: Dentists who have signed participating agreements with Delta Dental of Kentucky agree to accept the Allowable Amount as payment in full for Covered Services as these terms are defined in the Certificate of Coverage. Each Covered Person is responsible for the amount of Coinsurance, Deductible, and non-covered charges. Dentists who have not signed a participating agreement may bill you directly for any amount of their charge in excess of the Allowable Amount. In cases where the dentist's charges exceed the Allowable Amount, your coinsurance will be larger. Certain procedures require preauthorization and/or are subject to limitations.

Customer Service
1-800-955-2030
Visit out website to check your benefits and claims.
www.deltadentalky.com