



P.O. Box 1809
 Alpharetta, GA 30023-1809
 1-800-521-2651
 Fax: 770-641-5393

Delta Dental Insurance Company ENROLLMENT/CHANGE FORM Moss Point School District

Please Designate 10 or 12 Month

For Employer Use Only	
Effective Date	Group No.
Full Time Hire Date	19487
	Sublocation

Check One (**Enrollees can change plans only during open enrollment.)

Please make a selection: HIGH PLAN LOW PLAN

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

New Hire
 Open Enrollment
 Change Dental Plans**
 COBRA
 Add/Delete Dependent
 Terminate Employee Coverage
 Spouse Employment Change
 Marital Change
 Other _____

Indicate qualifying date:
 (Month) ____ (Day) ____ (Year) ____

Name: _____ (Last, First)
 Mailing Address: _____ (Street Address)
 _____ (City) _____ (State) _____ (Zip)
 Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: _____ (Month) ____ (Day) ____ (Year)
 Name of Employer/Group **Moss Point School** Location _____ (Pay Period - applicable)
 Marital Status: Single Married Gender: Male Female Phone # (____) _____ - _____
 Do you have dependent children? Yes No Are you or your dependents covered under another dental plan? Yes No

COBRA Enrollment Only

Please indicate qualifying event:
 Termination
 Reduction in Hours
 Divorce
 Widowed/Surviving Dependent
 Dependent Child No Longer Eligible

Indicate qualifying date:
 (Month) ____ (Day) ____ (Year) ____

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY To add additional dependents, please attach a separate sheet.)
 PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

Employee Only - please check this box if NOT covering dependents

Spouse/Dependent	Relationship	Gender	Date of Birth	Age	Marital Status	Phone #
Spouse: _____	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	(____) _____ - _____
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	
Dependent: _____	<input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	(Month) ____ (Day) ____ (Year) ____	____	____	

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____

Keep Smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your

plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁴ You can find this date by logging in to your online account.

Newly covered?

Visit deltadentalins.com/welcome.

Save with a PPO dentist



PPO



NON-PPO

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

Plan Benefit Highlights for: Moss Point School District
(Low Plan)

Group No: 19487

Effective Date:

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26		
Deductibles	\$50 per person / \$150 per family each calendar year		
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes		
Maximums	\$1,000 per person each calendar year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings and sealants	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Major Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	60 %	60 %
Prosthodontics Bridges and dentures	60 %	60 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Monthly Rates – Effective Dates (01/01/2019-12/31/2019)	10 Month Rate	12 Month Rate
Enrollee only	\$29.88	\$24.90
Employee + 1 or more dependents	\$88.50	\$73.75

Delta Dental Insurance Company 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009	Customer Service 800-521-2651	Claims Address P.O. Box 1809 Alpharetta, GA 30023-1809
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Plan Benefit Highlights for: Moss Point School District
(High Plan)

Group No: 19487

Effective Date:

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	\$50 per person / \$150 per family each calendar year			
Maximums D & P counts toward maximum?	\$2,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings and sealants	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Major Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Dependent children	50 %	50 %
Orthodontic Maximums	\$1,000 Lifetime	\$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Monthly Rates – Effective Dates (01/01/2019-12/31/2019)	10 Month Rate	12 Month Rate
Enrollee only	\$32.78	\$27.32
Employee + 1 or more dependents	\$100.72	\$83.93

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