P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-521-2651
www.deltadentalins.com

Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

For Employer Use Only	
Effective Date / /	Group No. 25-01125
Full Time Hire Date / /	Sublocation

Please select plan: **High Plan** ❑ **or** **Low Plan** ❑

division #: 00001 00002

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

- ❑ 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)

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)

Primary Enrollee Information

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

Name: (Last, First)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Social Security # ___ — ___ — ___ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group **Mississippi State University** Location

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 ❑

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

	Add	Delete	Male	Female	Date of Birth: (Month) (Day) (Year)
Spouse:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:
Dependent:	❑	❑	❑	❑	Date of Birth:

❑ 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 ______________

Form 3400HL (10-01)

Dental Insurance Premiums

Monthly Premiums

Monthly Rates	High Option	Low Option
Coverage For:	*Employee Pays*	*Employee Pays*
Employee Only	41.57	28.82
Employee + Family	86.49	60.13

Annual Deductibles

Annual Deductible	High Option	Low Option
Employee	50.00	50.00
Employee + Family	150.00	150.00

Plan Benefit Highlights for: Mississippi State University

Group No: 01125

Effective Date: 1/1/2020

DELTA DENTAL PPO[SM]

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) and Orthodontics, if applicable?	Yes			
Maximums	**Low Plan:** $1,000 per person each calendar year **High Plan:** $1,500 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits 12 Months	Prosthodontics 12 Months	Orthodontics 12 Months

	Low Plan		High Plan	
Benefits and Covered Services*	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings and posterior composites	50 %	50 %	80 %	80 %
Endodontics (root canals) Covered Under Major Services	25 %	25 %	50 %	50 %
Periodontics (gum treatment) Covered Under Major Services	25 %	25 %	50 %	50 %
Oral Surgery Covered Under Basic Services	50 %	50 %	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	25 %	25 %	50 %	50 %
Prosthodontics Bridges, dentures and implants	25 %	25 %	50 %	50 %
Orthodontic Benefits Dependent children	0 %	0 %	50 %	50 %
Orthodontic Maximums	N/A	N/A	$1,200 Lifetime	$1,200 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual 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	Low Plan	High Plan
Enrollee only	$28.82	$41.57
Enrollee + 1 or more dependents	$60.13	$86.49

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

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.

Delta Dental Enrollment Application for New Hires Instructions

Please select Plan

- Put a check mark in the box for high or low plan. This is the level of coverage you choose.

Check One

- Put a check mark in the New Hire box

Primary Enrollee Information

- Enter your name
- Enter social security number
- Enter date of birth
- Enter marital status
- Enter phone number
- Do you have dependent children? Choose appropriate box
- Are your children covered under another dental plan? Choose appropriate box

Dependent Information

- List eligible dependents to be covered in addition to yourself.
- Enter this information on the appropriate line
- Place a check mark in the add box
- Place a check mark in male or female box
- Enter date of birth for everyone listed

If you choose coverage place a check mark in the box beside:

- I authorized 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.

If you decline coverage place a check mark in the box beside:

- I decline coverage at this time.

Sign and date

Please send completed form to the Human Resource Department via:

- In person: 245 Barr Ave, 150 McArthur Hall
- U. S. Mail: PO Box 9603, Mississippi State, Ms 39762
- Fax: 662 325-0753
- Secure e-mail: contact your benefit specialist listed on the website: hrm.msstate.edu for information how to send secure email. To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603