DELTA DENTAL

ENROLLMENT FORM

Please print.

Delta Dental of Rhode Island
PO Box 1517
Providence, RI 02901-1517
800-84-DELTA

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)
Salve Regina University	1527-0001		

Social Security No. / Subscriber I.D. No.	Subscriber Name: First - Last	
Date of Birth - MM/DD/YYYY	Street Address / P.O. Box No.	Email Address
Effective Date of Action:	Apt. No. / City / State / Zip	

QUALIFYING EVENT

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers' Compensation
- ____ Return From Leave of Absence
- ____ Dependent's Loss of Coverage
- ____ Full-Time/Part-Time Status
- ____ Death of a Member

ACTION CODE (Check one. *Changes must be made on the first of the month.*)

ADDITIONS:

- ____ New Subscriber
- ____ Add Dependent to Family
- ____ Reinstatement

TERMINATION:

- ____ Remove Subscriber
- ____ Remove Dependent / Student (List dependent name.)

STATUS CHANGE:

- ____ Individual to Family
- ____ Family to Individual
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:

- ____ Reinstatement of Subscriber
- ____ Addition of Dependent — (From prior ID # _____)

DEPENDENT INFORMATION

Full Name (First, Last)	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

CORRECTIONS / OTHER REMARKS

TYPE OF COVERAGE (Check one) ☐ Individual ☐ Family

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Type of Coverage: ☐ Individual ☐ Family

Other Dental Insurance Name: _____

Other Dental Insurance Address: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Type of Coverage: ☐ Individual ☐ Family

Name of Medical Insurance Company/HMO: _____

Name of Health Plan/Type of Coverage: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

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Benefit Highlights

SALVE REGINA UNIVERSITY

Product Name: Delta Dental Premier
Plan Type: National Coverage

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%,80%) . Your group number is **1527-0001**. Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.

The annual maximum is:	$1,500.00 per member per calendar year
The annual deductible is:	$0.00
The maximum lifetime cap:	Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Oral exam - once every 6 months
- Cleaning - once every 6 months. More frequent cleanings may be allowed for pregnant women or patients with diabetes or compromised immune systems. Documentation is required.
- Fluoride treatment for children under age 19 once every 12 months. Fluoride varnish once every 12 months for members over age 16 following gingival flap or osseous surgery.
- Bitewing x-rays - one set every 12 months
- Complete x-ray series or panoramic film once every 60 months
- Single x-rays as required
- Sealants for children under age 16, once every 24 months on unrestored permanent bicuspids & molars
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months

Plan pays 80%; Member Coinsurance 20%

- Periodontal maintenance following active therapy, once every 3 months. If alternating with routine cleanings, there must be 3 months between a cleaning and the next maintenance procedure.
- Crowns over natural teeth, build ups, post and cores - replacement limited to once every 84 months
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 24 months.
- Gingivectomies once per site every 24 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months
- Guided tissue regeneration and bone replacement graft once per site every 24 months

Plan pays 50%; Member Coinsurance 50%

- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Surgical placement of endosteal implant, abutment and crown once per tooth site per lifetime

Dependent coverage - Dependent children are covered up until the end of the year that they turn age 19. Dependent children who are full-time students over age 19 are covered as long as they stay in school or up until the end of the year that they turn age 25.