



574 Boston Road  
P.O. Box 5059  
Billerica, MA 01822-5059  
Telephone (978) 663-3232  
(800) 464-0039  
Fax (978) 663-5431



## One Person Dental Available to One Person Companies And Businesses With 2 or More Employees

Thank you for your interest in **Northeast Business Trust** and the comprehensive group dental plans offered to our membership. **Altus Dental Insurance Company, Inc.** has quickly become one of the fastest growing dental benefits companies in Massachusetts. Altus currently services over 600,000 members, 5,000 employer groups and has 2,150 Dental Locations in Massachusetts.

### *Look at These Highlights*

- **100%** coverage for diagnostic and preventive services
- **No claim forms** when visiting a participating dentist; ID card only
- Orthodontic benefit for Dependents under 19
- Coverage for non-participating dentists

**See Reverse Side for Plan Benefit Highlights and Rates!**

### **HOW TO ENROLL FOR COVERAGE**

*See Eligibility and Participation Requirements on Membership Application*

- 1) **Sole Proprietor** or **Employer** completes **Employer Application**
- 2) **Sole Proprietor** provides copy of most recent **Schedule C Employer** (2 or more employees) provides **WR-1 New Businesses**, the owner must provide copies of D.B.A. certificate, Business License, Articles of Incorporation or other proof deemed appropriate by N.B.T.
- 3) **Sole Proprietor** or each **Employee** applying for coverage, **including owner**, must complete individual **Enrollment Form**
- 4) Each **EE waiving dental** coverage must complete a **Waiver Form** with **Proof of Coverage**
- 5) Enclose first month's premium - payable to: **Northeast Business Trust (NBT)**
- 6) Enclose annual dental membership check for \$25 (payable to NBT)

**Effective Dates** - Applications received by the end of the month will be effective the first of the following month.

Additional Enrollment or Waiver Forms may be  **duplicated**  or  **copied** .

**Forward all enrollment materials to:** Northeast Business Trust Inc.  
574 Boston Road - PO Box 5059  
Billerica, MA 01822-5059

If you have any questions or would like additional information, please call **1-800-464-0039**.

Available to One Person Companies  
And Businesses with 2 or More Employees



## Plan Benefit Highlights

In-Network

Out-of-Network

### DIAGNOSTIC AND PREVENTIVE SERVICES

Plan Pays

Cleanings (2 per year)  
Oral Exams (2 per year)  
Flouride Treatments (2 per year)  
X-Rays  
Sealants

100%

80%

### MINOR RESTORATIVE\* (6 Month Waiting Period)

Space Maintainers  
Denture Repairs  
Palliatives Treatment  
Filling  
Simple Extractions  
Oral Surgery/Anesthesia  
Endodontics  
Periodontic Cleanings  
Periodontic Surgery

50%

40%

### MAJOR RESTORATIVE\* (12 Month Waiting Period)

Crowns  
Prosthodontics

50%

40%

### ORTHODONTICS\*\* (24 Month Waiting Period)

For Dependants up to Age 19

50%

40%

### CALENDAR YEAR DEDUCTIBLE

\* Annual Deductible  
\$50 Individual  
\$150 Family

Calendar Year Maximum  
\*\*Orthodontic Lifetime Maximum  
Student Coverage

\$1,000

\$1,000

Age 23

### MONTHLY PREMIUM RATES \*\*\*

Employee  
EE & Spouse  
EE & Child  
Full Family

\$35.68

\$71.11

\$74.18

\$98.86

\*\*\*Rates are guaranteed to October 31st, 2006

Out-of-network payments are based on the reasonable and customary charge for the dentists' area.



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# NBT Membership Application

2006 V1

<b>Employer (Correct Legal Name)</b>		<b>Date Business Established (Mo./Yr.)</b>		
<b>Employer's Business Address (street, city, state, zip)</b>		<b>Telephone ( )</b>		
<b>Name of Owner/Principal Contact</b>	<b>Title</b>	<b>Fax ( )</b>		
<b>Billing Address (street, city, zip) If different than the business address</b>				
<b>Type of Business</b> <input type="checkbox"/> <b>Corporation</b> <input type="checkbox"/> <b>Partnership</b> <input type="checkbox"/> <b>Proprietorship</b> <input type="checkbox"/> <b>Other (explain below)</b>				
<b>Nature of Business</b>	<b>SIC code (4 digits)</b> [ ] or <b>NAICS code (6 digits)</b> [ ]	<b># Full-time Employees (30 hours or more)</b>	<b># Part-time Employees</b>	<b>Employer's Tax ID #</b>
<b>Primary Business Activity</b>				
Finance Insurance	Retail	Real Estate		
Construction	Manufacturing	Wholesale		
Professional	Service	Transportation	Other _____	
<b>Areas of Interest</b>				
Group HMO Plans	Retirement Planning	Discounted Telephone Service		
Low Cost Term Life	Group Dental & Vision	Discounted Car Rental		
Group Salary Continuation	Discounted Computers	Discounted Shipping		
<b>I certify that the information on this form is true and complete.</b>				
<b>Signature (Authorized Employer Representative)</b>		<b>Title</b>	<b>Date</b>	

<b>Broker Name (If Applicable)</b>	<u>Street, City, State, Zip</u>	Telephone <u>781-749-1079</u>
Richard P Hawkins, CLU	132 Main Street, Hingham, MA 02043	E-Mail <u>rphawkins@Verizon.net</u> Fax <u>775-307-9097</u>

For NBT Use Only	Account No.	Effective Date	Approved By	Date	Account Rep <b>7661</b>
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## One Person Dental EMPLOYER APPLICATION

Employer (Correct Legal Name)		Type of Business	<input type="checkbox"/> Sole Proprietor
			<input type="checkbox"/> Partnership
			<input type="checkbox"/> Corporation
Address (Street)	City	State	Zip Code
Telephone Number Area Code (    )	Principal Contact for Program		Title
Desired Effective Date (Must be 1st of the month)		Nature of Business	

ELIGIBILITY & PARTICIPATION REQUIREMENTS	ENROLLMENT INFORMATION
<p><b>ELIGIBLE COMPANIES:</b> A firm with 1 or more full-time employees that maintains a membership in Northeast Business Trust</p> <p><b>ELIGIBLE EMPLOYEES:</b> All full-time employees working at least <b>20 hours</b> per week</p> <p><b>WAIVER:</b> EE's covered on a spouses family dental plan can be excluded; a Waiver Form must be completed with proof of coverage</p> <p><b>PARTICIPATION REQ:</b> <b>70%</b> of the eligible employees must be enrolled</p> <p><b>EMPLOYER CONTRIB:</b> The employer must contribute at least 50% of the EE's premium</p> <p><b>NEW HIRES:</b> All future eligible employees may be enrolled the first month following 30 days of hire or within a time frame consistent with company policy.</p>	<p>_____ Total # of employees (including owners)</p> <p>_____ Subtract # of EE's under 20 hrs/week</p> <p>_____ Subtract # of EE's covered by spouses dental plan</p> <p>_____ <b>Total # of eligible EE's</b></p> <p>_____ <b>Total # of EE's enrolling</b> (Minimum 70% of eligible EE's)</p>

### MONTHLY PREMIUM CALCULATION

ALTUS ONE-PERSON DENTAL					
Type of Coverage	# of Elig		Month Rate	=	Premium
	EE's	x			
EE Only		x	\$35.68	=	\$
EE & Spouse		x	\$71.11	=	\$
EE & Child		x	\$74.18	=	\$
Full Family		x	\$98.86	=	\$
Subtotal					\$
Total					\$

I certify that the information on this application is true and complete

Signature (Authorized Employer Representative)	Title
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<b>Broker Name</b>		<u>Street, City, State, Zip</u>	<u>Telephone</u>
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<b>Official Use</b>	Account No.	Effective Date	Approved By	Date	Representative
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# ENROLLMENT FORM

Please print. Complete form to ensure enrollment.

Employer Group Name		Altus Dental Group Number		Date of Hire		Location No. (if applicable)	
Social Security No. / Subscriber I.D. No.		Subscriber Name: First (8 Characters) Last (16 Characters)					
Date of Birth		Street Address / P.O. Box No.					
Effective Date of Action:		Apt. No.		City		State	Zip

**QUALIFYING EVENT**

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Workers Compensation
<input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Family Medical or Disability Leave
<input type="checkbox"/> Marriage	<input type="checkbox"/> Spouse's Loss of Coverage
<input type="checkbox"/> Divorce	<input type="checkbox"/> Full Time/Part Time Status
<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Death of a Member

**DEPENDENT INFORMATION**

First Name Only <small>If last name differs, please indicate in "other remarks" below.</small>	Date of Birth	Student Rider <b>(over age 19)</b>
Spouse		Please check box below if full-time student.
Children		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

**ACTION CODE** (Check One) *(Changes must be made on the first of the month)*  
 Explain in "Other Remarks" if necessary.

**ADDITIONS:**

New Subscriber  
 Add Dependent to Family  
 Reinstatement

**TERMINATION:**

Remove Subscriber  
 Remove Dependent / Student

**STATUS CHANGE:**

Change "Type of Coverage"  
 Please indicate change (e.g. Individual to Family) in the section below.  
 Name / Address Change  
 Transfer from Sublocation # \_\_\_\_\_ to # \_\_\_\_\_

**COBRA:**

Reinstatement of Subscriber  
 Addition of Dependent — (From prior ID # \_\_\_\_\_)

**DENTIST INFORMATION**

List the dentists you or your covered family members use:

Dentist(s) Last Name	First Name	City/Town

**CORRECTIONS / OTHER REMARKS**

(Please Explain)

**Type of Coverage** (Check One)     Individual     Individual & Spouse     Family     Individual & Child/Children

**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.

Other Dental Insurance Name: \_\_\_\_\_ Type of Coverage:  Individual     Family

Other Dental Insurance Address: \_\_\_\_\_

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

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

Name of Medical Insurance Company/HMO: \_\_\_\_\_ Type of Coverage:  Individual     Family

Name of Health Plan/Type of Coverage: \_\_\_\_\_

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

Group Policy No.	Policy Holder Name	Policy Holder ID No.
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*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 Altus Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.*

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Benefits Administrator Authorization \_\_\_\_\_ Date \_\_\_\_\_



One Person Dental Plan

Waiver of Coverage Form

Company Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reasons for Waiving Coverage (check one):

\_\_\_ Covered through parent's Dental plan

\_\_\_ Covered through spouse's employer's Dental plan

Employer name \_\_\_\_\_

Dental Carrier \_\_\_\_\_

Must provide copy of dental I.D. card or copy of coverage certificate

\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_

Signature of the Employee

Date

This form may be duplicated



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**AUTHORIZATION AGREEMENT TO HONOR PRE-AUTHORIZED PAYMENTS  
DRAWN BY AND PAYABLE TO NORTHEAST BUSINESS TRUST**

\_\_\_\_\_  
Company Name (As appears on your NBT bill): \_\_\_\_\_

Company Account Number (As appears on your NBT bill): \_\_\_\_\_

I (We) hereby request and authorize Northeast Business trust ("NBT") to initiate withdrawals from my (our) checking account indicated below at the depository named below. Said withdrawals to be used as payment for full monthly balance due on the above named account and company. This authorization is to remain in full force and effect until NBT has received written notification from me (us) revoking the authorization agreement in such time as to afford NBT a reasonable opportunity to act on it.

Depositor Name (as appears on account): \_\_\_\_\_

Depository (Bank) Name: \_\_\_\_\_ Branch: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Account Number: \_\_\_\_\_  Checking  Savings

Routing Number (9 Digits): \_ \_ \_ \_ \_

Name (please print): \_\_\_\_\_

Signature: X \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
ATTACH VOIDED CHECK HERE