



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

## Delta Dental of Massachusetts

### Available to Firms with 2 or More Employees

Thank you for your interest in **Northeast Business Trust** and the comprehensive group dental plans offered to our membership.

**Delta Dental** is the largest provider of dental benefits in Massachusetts. Delta Dental offers comprehensive dental care that emphasizes the preventive services that enable you to enjoy good dental health. These plans include diagnostic, preventive, basic and major restorative services.

#### *Look at These Highlights*

- **Choice of plans** to fit your companies needs
- **No waiting periods** for any covered benefits
- **100%** coverage for diagnostic and preventive services
- **Child and Adult Orthodontic benefits** available with DeltaCare
- **No claim forms** when visiting a participating dentist; ID card only
- No lifetime maximums
- Dependents covered to age 19; Full-time students covered to age 23
- Benefits also available for services rendered by non-participating dentists

**Please See Reverse Side for Plan Benefits and Rates!**

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

*See Eligibility and Participation Requirements on Membership Application*

- 1) Employees may choose either the **Delta Dental Premier** or **DeltaCare**
- 2) **Employer** completes **Group Application**
- 3) **Employer** provides copy of most recent **WR-1**
- 4) Each **employee** must complete individual **Enrollment Form (Indicate choice of plan)**
- 5) Each **EE waiving dental** coverage must complete a **Waiver Form with Proof of Coverage**
- 6) Enclose first month's premium - payable to: **Northeast Business Trust (NBT)**
- 7) 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**.

Delta Dental Premier (over 5000 Dentists)	Benefit Highlights	DeltaCare (475 Dentists)
2006 V1	<b>TYPE I - DIAGNOSTIC AND PREVENTIVE SERVICES</b>	<b>Patient Co-Payments</b>
<b>100%</b>	<ul style="list-style-type: none"> <li>• <b>Diagnostic:</b> <ul style="list-style-type: none"> <li>Initial oral exam and charting (once per Dentist) \$0</li> <li>Periodic oral exam (once <b>every</b> 6 months) \$0</li> <li>Full mouth X-rays (once every 60 months) \$0</li> <li>Bite wing X-rays \$0</li> <li>Single tooth X-rays (As needed) \$0</li> </ul> </li> <li>• <b>Preventive:</b> <ul style="list-style-type: none"> <li>Oral prophylaxis - cleaning, scaling and polishing \$0</li> <li>Flouride treatment \$0</li> </ul> </li> </ul>	
	<b>TYPE II - RESTORATIVE AND OTHER BASIC SERVICES</b>	
<b>80%</b>	<ul style="list-style-type: none"> <li>• <b>Restorative:</b> <ul style="list-style-type: none"> <li>One surface silver filling; permanent tooth \$11</li> <li>One surface white filling front tooth \$13</li> </ul> </li> <li>• <b>Oral Surgery:</b> <ul style="list-style-type: none"> <li>Simple surgical tooth removal \$26</li> </ul> </li> <li>• <b>Periodontic:</b> <ul style="list-style-type: none"> <li>Gum surgery; gingival curettage \$60</li> <li>Periodontal scaling, per quadrant \$15</li> </ul> </li> <li>• <b>Endodontics:</b> <ul style="list-style-type: none"> <li>Root canal treatment; anterior tooth \$70</li> <li>Surgical Root canal treatment \$66</li> </ul> </li> <li>• <b>Prosthetic Maintenance:</b> <ul style="list-style-type: none"> <li>Rebase denture; partial, upper or lower \$45</li> <li>Reline denture; complete, upper or lower \$30</li> </ul> </li> <li>• <b>Emergency Dental Care:</b> <ul style="list-style-type: none"> <li>Emergency treatment for relief of pain \$10</li> </ul> </li> </ul>	
	<b>TYPE III - MAJOR RESTORATIVE SERVICES</b>	
<b>50%</b>	<ul style="list-style-type: none"> <li>• <b>Major Restorative:</b> <ul style="list-style-type: none"> <li>Porcelain and base metal crown \$305 + Lab</li> <li>Porcelain and noble metal crown \$322 + Lab</li> </ul> </li> <li>• <b>Prosthetic:</b> <ul style="list-style-type: none"> <li>Upper partial denture; resin \$300</li> <li>Bridge pontic: base metal \$305 + Lab</li> </ul> </li> </ul>	
	<b>ORTHODONTICS</b>	
<b>Not Available</b>	<p style="text-align: center;"><b>Child and Adult Coverage</b></p> <p style="text-align: center;">Fee Allowance Based on Treatment Schedule</p>	Pre-ortho Visit \$25 Pre-ortho records \$200 Dependent Child to age 19 <i>(Up to 24 months \$1950)</i> Adult & FT students <i>(Up to 24 months \$2150)</i>
	<b>Calendar Year Deductibles</b>	
<u><b>Type I Services</b></u> None <u><b>Type II an III Services</b></u> \$50 Per Person \$150 Family Maximum		None
	<b>Calendar Year Maximums</b>	
\$1,200 Per Person		\$1000 per person (periodontal, endodontic and oral surgery)
	<b>Monthly Premium Rates</b>	
<b>\$48</b> <b>\$93</b> <b>\$111</b>	Employee <b>\$32</b> Dual-(Two Person) <b>\$56</b> Full Family <b>\$85</b>	

Rates are Guaranteed until July 1, 2006



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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> <u>Corporation</u> <u>Partnership</u> <u>Proprietorship</u> <u>Other (explain below)</u>				
<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	Retail	Real Estate		
Insurance				
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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**EMPLOYER APPLICATION**



**Delta Dental Plan  
 of Massachusetts**

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 2 or more full-time employees (with 2 or more enrolling) that maintains a membership in Northeast Business Trust</p> <p><b>ELIGIBLE EMPLOYEES:</b> All full-time employees working at least 30 hours 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> 100% of the eligible employees must be enrolled and must remain on the plan for a minimum of one year</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 employees must be enrolled the first month following 30 days of continuous employment</p>	<p>_____ Total # of employees (including owners)</p> <p>_____ Subtract # of EE's covered by spouses dental plan</p> <p>_____ Total # of elig. EE's</p> <p>_____ % employer's contribution</p>

**MONTHLY PREMIUM CALCULATION**

DELTA PREMIER PLAN						DELTACARE PLAN					
Type of Coverage	# of Elig EE's	x	Month Rate	=	Premium	Type of Coverage	# of Elig EE's	x	Month Rate	=	Premium
EE Only		x	\$48	=	\$	EE Only		x	\$33	=	\$
EE & Spouse		x	\$93	=	\$	EE & Spouse		x	\$57	=	\$
EE & Child		x	\$93	=	\$	EE & Child		x	\$57	=	\$
Full Family		x	\$111	=	\$	Full Family		x	\$87	=	\$
Subtotal					\$	Subtotal					\$
Admin. Fee					\$ 10.00	Admin. Fee					\$ 10.00
Total					\$	Total					\$

Rates Guaranteed until 7/1/2006

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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Delta Dental Plan of Massachusetts

C/O Northeast Business Trust
P.O. Box 5059
Billerica, Ma. 01822-5059
Tel 800-464-0039
Fax 978-663-5431
e-mail sales@nbtgroup.com

ENROLLMENT FORM

PLEASE PRINT OR TYPE -
BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

1. GROUP NAME: NORTHEAST BUSINESS TRUST
2. EFFECTIVE DATE:
3. DATE OF HIRE:
4. GROUP NUMBER: 6624-
5. SOCIAL SECURITY NO.
6. LAST NAME (Subscriber):
7. FIRST NAME:
8. DOB:
9. SEX:
10. HOME ADDRESS
11. CITY:
12. STATE:13. ZIP:
14. COMPANY NAME:
15. WORK #:
16. HOME #:

PLAN SELECTION

17. PLAN: Select plan you are enrolling in:
[ ] DeltaPremier [ ] DeltaCare
If DeltaCare is selected, each subscriber & dependent must choose a DeltaCare Primary Care Dentist (PCD.)

PLEASE LIST ALL DEPENDENT(S) COVERED UNDER YOUR POLICY

Table with columns: 18. FIRST NAME, 19. LAST NAME, 20. DATE OF BIRTH, 21. SEX M/F, 22. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT, 23. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL, 24. PROVIDER #, 25. DO YOU CURRENTLY USE THIS DENTIST?
Rows: SUBSCRIBER, SPOUSE, CHILDREN

26. REASON FOR SUBMISSION (CHECK ONE)

- [ ] New Addition
[ ] Individual [ ] Individual + 1 [ ] Family
[ ] Status change (must be 1st of month)
[ ] Individual to Family [ ] Individual + 1 [ ] Family to Individual
[ ] Termination: Date of termination
[ ] Cobra - Reinstatement of subscriber
[ ] Add dependent to family
[ ] Cobra - new addition of dependent formerly covered under ID #
[ ] Reinstatement
[ ] Name / address change
[ ] Number of months Cobra eligible
[ ] Remove dependent from student status
[ ] Cobra - reinstatement - transfer to Cobra sublocation
[ ] Transfer from sublocation to

27. COORDINATION OF BENEFITS

Are [ ] you OR [ ] any other family member covered by another dental plan? [ ] No [ ] Yes
If YES, please indicate name of covered individual

OTHER DENTAL INSURANCE COMPANY: EMPLOYER NAME: POLICY HOLDER ID NO.: EFFECTIVE DATE

28. Are [ ] you OR [ ] any other family member covered by another medical plan? [ ] No [ ] Yes
If YES, please indicate name of covered individual

OTHER MEDICAL INSURANCE COMPANY: EMPLOYER NAME: POLICY HOLDER ID NO.: EFFECTIVE DATE

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 Plan of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

29. Subscriber Signature

Date

Benefit Administrator Authorization

Date



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# Waiver of Delta Dental Coverage Form

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

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

### Reasons for Waiving Dental Benefits (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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**PRE-AUTHORIZED CHECKING APPLICATION**

**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 made up to 5 days prior to the first of each month and 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**