



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



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.

Altus Dental Insurance Company, Inc. has quickly become one of the fastest growing dental benefits companies in Massachusetts. You can choose from either the highly affordable Altus preferred or Altus Preferred plus, with expanded out-of-network coverage. No matter which plan you choose, you will enjoy affordable premiums, excellent customer service and innovative online technology that makes it easy to manage your dental plan.

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
- **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

Please See Reverse Side for Plan Benefits and Rates!

HOW TO ENROLL FOR COVERAGE

See Eligibility and Participation Requirements on Membership Application

- 1) All employees **must** choose the **same dental plan**
- 2) **Employer** completes **NBT Membership Application**
- 3) **Employer** completes **Employer Application**
- 4) **Employer** provides copy of most recent **WR-1**
- 5) Each **employee** must complete individual **Enrollment Form**
- 6) Each EE **waiving dental** coverage must complete a **Waiver Form** with **Proof of Coverage**
- 7) Enclose first month's premium - payable to: **Northeast Business Trust (NBT)**
- 8) 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**.

Altus Dental Insurance Co., Inc.
Benefit Highlights

<u>Preferred Plus</u> Co-insurance		<u>Preferred</u> Co-insurance
100%	<p align="center">TYPE I - DIAGNOSTIC AND PREVENTIVE SERVICES</p> <ul style="list-style-type: none"> • Diagnostic: Two exams per calendar year* Full mouth X-rays Bite wing X-rays Single tooth X-rays (As needed) • Preventive: Two cleanings per calendar year Flouride treatment; twice per calendar year Sealants 	100%
50%	<p align="center">TYPE II - RESTORATIVE AND OTHER BASIC SERVICES</p> <ul style="list-style-type: none"> • Restorative: Silver fillings; permanent tooth White fillings; front tooth • Oral Surgery: Simple surgical tooth removal • Periodontic: Periodontal maintenance following active therapy twice per calendar year Periodontal scaling; per quadrant • Endodontics: Root canal treatment; anterior tooth Surgical Root canal treatment • Prosthetic Maintenance: Rebase denture; partial, upper or lower Reline denture; complete, upper or lower • Emergency Dental Care: Emergency treatment for relief of pain* • General Anesthesia: With covered surgical services (up to 15 minutes) 	100%
50%	<p align="center">TYPE II - PERIODONTIC SURGERY</p> <p align="center">Gum surgery; gingival curettage; crown lengthening</p>	Not Applicable
50%	<p align="center">TYPE III - MAJOR RESTORATIVE SERVICES</p> <p>Major Restorative: Porcelain and base metal crown Porcelain and noble metal crown</p> <p>Prosthodontic: Upper partial denture; resin Bridge ponic: base metal</p>	Not Applicable
<p><u>Type I Services</u> None</p> <p><u>Type II an III Services</u> \$50 Per Person \$150 Family Maximum</p>	Calendar Year Deductibles	* A fixed \$10 coinsurance applies to Type I exams and to type II emergency treatment
\$1,500 Per Person	Calendar Year Maximums	\$1,500 per person (periodontal, endodontic and oral surgery)
<p align="center">\$51 \$98 \$98 \$117</p>	<p align="center">Monthly Premium Rates</p> <p align="center">Employee EE & Spouse EE & Child Full Family</p>	<p align="center">\$51 \$98 \$98 \$117</p>

Rates are Guaranteed until July 1, 2007



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NBT Membership Application

2006 V2

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

Broker Name (If Applicable)	<u>Street, City, State, Zip</u>	<u>Telephone</u> _____ <u>E-Mail</u> _____ <u>Fax</u> _____
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For NBT Use Only	<u>Account No.</u>	<u>Effective Date</u>	<u>Approved By</u>	<u>Date</u>	<u>Account Rep</u>
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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		Principal Contact for Program		Title
Area Code ()				

Desired Effective Date (Must be 1st of the month)	Nature of Business
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ELIGIBILITY & PARTICIPATION REQUIREMENTS	ENROLLMENT INFORMATION
<p>ELIGIBLE COMPANIES: A firm with 2 or more full-time employees (with 2 or more enrolling) that maintains a membership in Northeast Business Trust</p> <p>ELIGIBLE EMPLOYEES: All full-time employees working at least 30 hours per week</p> <p>WAIVER: EE's covered on a spouses family dental plan can be excluded; a Waiver Form must be completed with proof of coverage</p> <p>PARTICIPATION REQ: 100% of the eligible employees must be enrolled</p> <p>EMPLOYER CONTRIB: The employer must contribute at least 50% of the EE's premium</p> <p>NEW HIRES: All future eligible employees must 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 covered by spouses dental plan</p> <p>_____ Total # of elig. EE's</p> <p>_____ % employer's contribution</p>

MONTHLY PREMIUM CALCULATION

PLEASE CHOOSE ONE PLAN FOR ALL EMPLOYEES

ALTUS PREFERRED PLUS					
Type of Coverage	# of Elig EE's	x	Month Rate	=	Premium
EE Only		x	\$51	=	\$
EE & Spouse		x	\$98	=	\$
EE & Child		x	\$98	=	\$
Full Family		x	\$117	=	\$
Subtotal					\$
Admin. Fee					\$ 10.00
Total					\$

OR

ALTUS PREFERRED					
Type of Coverage	# of Elig EE's	x	Month Rate	=	Premium
EE Only		x	\$51	=	\$
EE & Spouse		x	\$98	=	\$
EE & Child		x	\$98	=	\$
Full Family		x	\$117	=	\$
Subtotal					\$
Admin. Fee					\$ 10.00
Total					\$

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

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

P.O. Box 1557
Providence, RI 02901-1557
877-223-0588

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 If last name differs, please indicate in "other remarks" below.	Date of Birth	Student Rider (over age 19)
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 _____



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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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