DELTA DENTAL

# Delta Dental of Tennessee
# Superior Advantage™ Plan Application

## Subscriber Information

Name: _____ St: _____ Zip: _____
Address: _____ Phone: _____ Birth Date: / /
City: _____ SSN: _____
Email: _____

### Dependents to be covered (if any)

| Name | Birth Date | Relation (Spouse or Child) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Method of Payment (Select One)

☐ Monthly Credit Card: ☐ Visa ☐ MasterCard

*Card Number*

Exp. Date (mm/yy)

Or

☐ Monthly Bank Draft: Bank Name: _____
Account #: _____ Routing #: _____

## Certification and Agreement

The information contained in this application is true, complete and accurate. It is understood that the rates, terms, and conditions of any contract issued by Delta Dental of Tennessee shall be based on the information in this application. If any information or representation is not true, complete or accurate, Delta Dental of Tennessee may adjust the rates, terms or conditions and / or cancel any contract. You certify that you are applying for this policy in the State of Tennessee. This application shall become a part of the contract issued by Delta Dental of Tennessee. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

Individual hereby agrees that if Delta Dental of Tennessee accepts this application and issues a signed contract, the Individual shall be bound by the terms and conditions of said contract. Individual agrees to pay the premiums defined in the contract in accordance with the terms of the contract. Individual also recognizes that this contract may only be modified by written document issued by Delta Dental of Tennessee as defined in the contract.

Printed Name: _____ Signature: _____

Date: _____ Referred by (if any): _____ Broker Name (if any): _____

**Mail this completed and signed application to:**

**Delta Dental of Tennessee**
**Attn: Member Services**
**240 Venture Circle**
**Nashville, TN 37228**

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## Benefits

| Months Enrolled | 1-12 Months | | 13-24 Months | | 25-36 Months | | 36+ Months | |
|---|---|---|---|---|---|---|---|---|
| **Network Provider** | PPO | Non Par | PPO | Non Par | PPO | Non Par | PPO | Non Par |
| Diagnostic and Preventive | 100% | 80% | 100% | 80% | 100% | 80% | 100% | 80% |
| Sealants | 50% | 40% | 80% | 60% | 80% | 60% | 80% | 60% |
| Basic Services | 50% | 40% | 80% | 60% | 80% | 60% | 80% | 60% |
| Fillings | 50% | 40% | 80% | 60% | 80% | 60% | 80% | 60% |
| Endodontics | 25% | 10% | 50% | 40% | 50% | 40% | 50% | 40% |
| Periodontics | 25% | 10% | 50% | 40% | 50% | 40% | 50% | 40% |
| Complex Oral Surgery | 25% | 10% | 50% | 40% | 50% | 40% | 50% | 40% |
| Major Restorative | 25% | 10% | 50% | 40% | 50% | 40% | 50% | 40% |
| Prosthodontics | 25% | 10% | 50% | 40% | 50% | 40% | 50% | 40% |
| Implants | 25% | 10% | 50% | 40% | 50% | 40% | 50% | 40% |
| *Annual Maximum* | *$500* | | *$1,000* | | *$1,250* | | *$1,500* | |
| *Single/Family Deductible** | *$50/$150* | | *$50/$150* | | *$50/$150* | | *$50/$150* | |

*Deductible does not apply to in network diagnostic and preventive services.

| Premium+ | Monthly Premium | Monthly Billing Fee | Total Monthly Rate |
|---|---|---|---|
| Subscriber only | $31.63 | $ 2.50 | $34.13 |
| Subscriber + 1 dependent | $61.82 | $ 2.50 | $64.32 |
| Subscriber + 2 or more dependents | $98.42 | $ 2.50 | $100.92 |

+There is a one-time $25 application fee

### Did You Know?

120 symptoms of diseases like cancer, diabetes, and stroke can be detected in a routine dental exam.

Learn more and find information about how you can protect your smile when you visit www.DeltaDentalTn.com.

@DeltaDentalTN