Total Dental Rates

Employee Only
Employee + 1 Dependent
Employee + 2 or More Dependents

2017 Monthly Rates
$30.28
$57.66
$96.40

2017 Elite Choice
Dental Plan

Calendar Year Deductible
Waiting Periods for Covered Services
Annual Benefit Maximum per Person
Balance Billing Allowed
Cleanings, Exams, X-rays, Fillings,
Crowns, Oral Surgery, Endodontics,
Periodontics, Prosthodontics

Competitive Monthly Premium Rates

TDA In-Network
Coverage

NONE!
NONE!
$2,000!
NO!
FIXED, PUBLISHED COPAYS!
YOU KNOW HOW MUCH
SERVICES WILL COST!
HELPS YOU BUDGET!
YES!

WHO TO CALL

Feel free to call or email a TDA representative with questions or for assistance:

Ron Holden
(701) 721-3716
RHolden@Minot.com

Chris Jehle
(602) 320-3261
ChrisJehle@Cox.net

The benefits described herein are a brief and incomplete list of all covered services. A complete listing of all benefits, limitations and exclusions are contained in the Certificate of Coverage and is available prior to enrollment upon request. In the case of discrepancy between or among documents, the terms of the Certificate of Coverage shall govern above all other plan documents.

11/2016w
GROUP DENTAL ENROLLMENT FORM

- New Employee  - Add/Delete Dep.  - Transfer from DHMO  - Cancel Coverage  - COBRA Enrollment
- Open Enrollment  - Rehire  - Address/Name Change  - Loss of Other Coverage  - Transfer from PPO

Name of Employer: University of North Dakota

Group Number: BUE-NDE14990

Plan Types: Elite Choice Dental Plan

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<thead>
<tr>
<th>Social Security Number:</th>
<th>Effective Date</th>
<th>Date Employed Full Time</th>
<th>Hours Worked</th>
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<td>Mo / Day / Year</td>
<td>Month / Day / Year</td>
<td>Per Week</td>
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Last Name: [ ] First Name: [ ] MI: [ ] Date of Birth: [ ] Sex: [ ]

Home Address:
Street: __________________________
Apartment #: ______________________
City, State, Zip: __________________
Home Phone: ______________________ Work Phone: __________________

Do you have other Dental Coverage? If yes, Carrier:

Complete for Dependent Coverage:

<table>
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<tr>
<th>Dependent</th>
<th>First</th>
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<th>Date of Birth</th>
<th>Name of Other Dental Carrier</th>
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I ELECT THE DENTAL COVERAGE selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages. I hereby apply for enrollment and agree to remain in the Plan a minimum of one year, authorize the release of any information relating to dental care received under the Plan, and to all terms and conditions set forth in the Group Agreement.

Date: [ ] Employee Signature:

REFUSAL OF GROUP DENTAL COVERAGE: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date: [ ] Employee Signature:

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