

# Dental and Vision for Everyone

## Dental Price Areas

### Premier/Price Areas

States	Zip Code	Area
Alabama	350-355, 359	2
	All Others	1
California	900-904, 915-918	7
	905	6
	956-958	4
	906-914, 919-927, 930-939, 949,	6
	952, 955, 959-961	6
	All Others	4
Delaware	All	2
District of Columbia	All	5
Florida	320-322	4
	330-334	5
	All Others	3
Georgia	300-303	2
	All Others	3
Louisiana	712	3
	707-711	2
	All Others	1
Maryland	207-212	4
	All Others	2
Mississippi	390-392	2
	All Others	1
Montana	590-591, 599	1
	All Others	2
Nevada	893-898	5
	All Others	4
New York	100-102	7
	103-114	6
	115-119	5
	120-129	4
	All Others	3
Pennsylvania	189, 193-194	4
	190-191	3
	All Others	2
Texas	754	4
	751-753	3
	756-757, 776-777	1
	All Others	2
Utah	All	5
West Virginia	255-257, 262-265	2
	All Others	1

### PPO/Price Areas

States	Zip Code	Area
Alabama	350-355, 359	3
	All Others	2
California	900-904, 915-918	7
	905	6
	956-958	4
	906-914, 919-927, 930-939, 949,	6
	952, 955, 959-961	6
	All Others	4
Delaware	All	4
District of Columbia	All	7
Florida	320-322	5
	330-334	4
	All Others	3
Georgia	300-303	2
	All Others	3
Louisiana	712	3
	707-711	2
	All Others	1
Maryland	207-212	5
	All Others	4
Mississippi	390-392	2
	All Others	1
Montana	590-591, 599	1
	All Others	2
Nevada	893-898	5
	All Others	4
New York	100-102	8
	103-114	7
	115-119	7
	120-129	5
	All Others	4
Pennsylvania	189, 193-194	6
	190-191	4
	All Others	3
Texas	754	4
	751-753	3
	756-757, 776-777	1
	All Others	2
Utah	All	5
West Virginia	255-257, 262-265	4
	All Others	3

### Benefits Association Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee:			Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Last Name	First	Initial		
Home Phone	Street				
	City	State	Zip	Date _____	

"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthly membership fee is \$1.00 and is included in the monthly rates."

**Member Signature:**

\_\_\_\_\_

# Monthly Rates

## Premier Rates

Area	Member	Plus One	Family
1	\$36.64	\$66.70	\$96.76
2	\$40.12	\$73.48	\$106.85
3	\$43.98	\$81.02	\$118.05
4	\$48.27	\$89.38	\$130.49
5	\$53.03	\$98.66	\$144.29
6	\$58.32	\$108.96	\$159.61
7	\$64.18	\$120.40	\$176.62

*Includes: \$4.00 Billing Fee, \$1.00 Association Dues, and 4% Administration Fee*

**Premier coverage** rates are based on Delta Dental's Premier network. Both Premier and Non-Delta Dental dentists are reimbursed on Usual, Reasonable and Customary (UCR) charges. The Premier dentist will file the claim with Delta Dental and will not balance bill. Locate Premier Providers at [www.deltadentalins.com](http://www.deltadentalins.com).

## PPO Plan Rates

Area	Member	Plus One	Family
1	\$29.68	\$53.12	\$76.57
2	\$32.39	\$58.42	\$84.44
3	\$35.41	\$64.29	\$93.18
4	\$38.75	\$70.82	\$102.88
5	\$42.46	\$78.06	\$113.65
6	\$46.59	\$86.09	\$125.60
7	\$51.16	\$95.01	\$138.86
8	\$56.24	\$104.91	\$153.59

*Includes: \$4.00 Billing Fee, \$1.00 Association Dues, and 4% Administration Fee*

**PPO coverage** rates are based on Delta Dental's PPO network. Benefits for all dentists are based on Delta Dental's reduced PPO fee schedule. PPO dentists will file the claim with Delta Dental.

There is no balance billing for PPO dentists. Locate PPO Providers at [www.deltadentalins.com](http://www.deltadentalins.com).

## Dental For Everyone Enrollment Card

Please choose:  Delta Dental Premier®  Delta Dental PPO

### MODE OF PAYMENT

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly  <input type="checkbox"/> Bankdraft <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard BANKDRAFT: This is authorization for Morgan-White, on behalf of Delta Dental Insurance Company to draft payments from my checking account for payment of my insurance premiums. Enclosed is a blank voided check on the bank on which drafts are to be drawn.
Home Phone	Street					
	City	State	Zip			
E-mail address:						

### LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different)	First Name	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
2. Spouse				<input type="checkbox"/> M <input type="checkbox"/> F
3. Dependents				<input type="checkbox"/> M <input type="checkbox"/> F
4.				<input type="checkbox"/> M <input type="checkbox"/> F
5.				<input type="checkbox"/> M <input type="checkbox"/> F
6.				<input type="checkbox"/> M <input type="checkbox"/> F
7.				<input type="checkbox"/> M <input type="checkbox"/> F

Credit Card #: \_\_\_\_\_

Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

"I understand and agree that (1) the insurance shall not take effect unless the enrollment has been accepted and approved by Delta Dental Insurance Company and (2) the agent does not have the authority to make or alter any contract or waive any of Delta Dental's other rights or requirements."

Association Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

AGENT NAME (if applicable): DONALD KENTON HENRY

AGENT # (Your state license #): TX 651676