Taking Care of Your Oral Health is All Part of Taking Care of You

For over 20 years, TDA has offered coverage that does just that, takes care of your oral health with simplicity and budget-conscious dental plans. Now you can manage your oral health while saving on dental insurance premiums in 2020 with TDA.

BANG FOR YOUR BUCK

- $2,000 annual benefit
- No in-network waiting periods
- In and out-of-network dental coverage

THE PLAN WITH NO SURPRISES

- Straightforward copays for services
- You know your costs before you get care
- No in-network deductibles or coinsurance

A BUDGET CONSCIOUS PLAN

- Lower cost premiums
- Maintain good oral health with copays for most-used services
- Coverage in case of a major dental need

2020 MONTHLY PREMIUM RATES

Elite Choice covered benefits and copays for the 2020 Plan Year are unchanged from the previous year.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>2020 Plan Year Monthly Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$36.98</td>
</tr>
<tr>
<td>Employee + 1 Dependent</td>
<td>$69.96</td>
</tr>
<tr>
<td>Employee + 2 or More Dependents</td>
<td>$116.60</td>
</tr>
</tbody>
</table>

QUESTIONS FOR TDA

Please feel free to call or email our TDA representatives if you would like more information.

RON HOLDEN
(701) 721-3716
RHolden@Minot.com

CHRIS JEHLE
(602) 320-3261
CJehle@dmcaz.com
NAME OF EMPLOYER: (Use Name from Group Billing Notice or Master Application)  

University of North Dakota

GROUP DENTAL ENROLLMENT FORM

☐ New Employee  ☐ Add Coverage  ☐ Add/Delete Dependent  ☐ Decline Coverage  ☐ Cancel Coverage

☐ Address/Name Change  ☐ Loss of Other Coverage  ☐ Transfer From DHMO  ☐ Transfer From PPO  ☐ COBRA Enrollment

Name of Employer: University of North Dakota  
Group Number: BUE NDE14990  
Class: New Employee

Plan Types:  

☐ Elite Choice Plan

Social Security Number  
Effective Date  
Month / Day / Year

Date Employed Fulltime  
Month / Day / Year

Hours Worked Per Week

Your Name (Last), (First), (MI)

Date of Birth  
Month / Day / Year

Sex:  
Male: ☐  
Female: ☐

Home Address:

Home Phone Number:  
Work Phone Number:

Do you have any other Dental coverage? If so, Carrier:

Complete for Dependent Coverage:

Spouse Name: (Last), (First), (MI)  
Date of Birth: / / 

Sex: 
Yes ☐ No ☐

1. CHILDREN

2. CHILDREN

3. CHILDREN

4. CHILDREN

5. CHILDREN

6. CHILDREN

Do any of your dependents have any other dental coverage? If so, Name of Carrier:

Yes ☐ No ☐

Fraud Warning (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

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.

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.

Employee Signature: ______________________

Return To:
Total Dental Administrators, Inc.
2800 North 44th Street, Suite 500
Phoenix, Arizona 85008
1-888-422-1995
customerservice@TDAdental.com
eforms@TDAdental.com