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 2021 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

2021 MONTHLY PREMIUM RATES

Elite Choice covered benefits and copays for the 2021 Plan Year are unchanged from the previous year.

<table>
<thead>
<tr>
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<th>2021 Plan Year Monthly Rates</th>
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<tbody>
<tr>
<td>Employee Only</td>
<td>$36.98</td>
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<tr>
<td>Employee + 1 Dependent</td>
<td>$69.96</td>
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<tr>
<td>Employee + 2 or More Dependents</td>
<td>$116.60</td>
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</tbody>
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QUESTIONS FOR TOA

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

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

**CHRIS JEHLE**
(602) 320-3261
CJehle@dmcaz.com
GROUP DENTAL ENROLLMENT FORM

Name of Employer: (Use Name from Group Billing Notice or Master Application)  Group Number:  Class:

UNIVERSITY OF NORTH DAKOTA  BUE NDE14990

Plan Type:

X Elite Choice Plan

Social Security Number

Effective Date
Month / Day / Year
1/1/2020

Date Employed Fulltime
Month / Day / Year

Hours Worked Per Week

Your Name (Last), (First), (M)

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

Coverage Requested:

- Employee Only
- Employee + 1
- Employee + 2 or More

Complete for Dependent Coverage:

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

Spouse Name: (Last), (First), (M)

Date of Birth:

Children:

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<tr>
<th></th>
<th>Sex</th>
<th>Date of Birth:</th>
<th>Yes</th>
<th>No</th>
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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 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.

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:

Return To:
UND Payroll Office
Twamley Hall Rm 312
264 Centennial Dr Stop 7127
Grand Forks, ND 58202