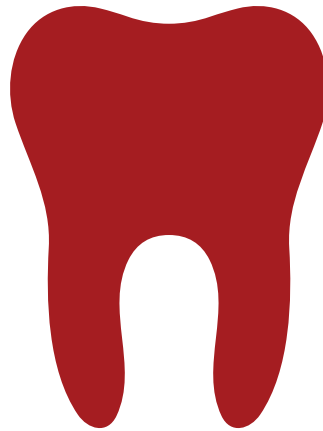




EMPLOYEE
ADMINISTRATIVE
SERVICES, INC.

DENTAL PLAN



	Current Rates
Employee Only	\$41.92
Employee with One Dependent	\$81.93
Employee and Family	\$120.41

itsEASIPayroll.com

601-956-9764 • 689 Towne Center Boulevard Ridgeland, MS 39157



Delta Dental Insurance Company
ENROLLMENT/CHANGE FORM

P.O. Box 1809
 Alpharetta, GA 30023-1809
 1-800-521-2651
 Fax: 770-641-5393

For Employer Use Only	
Effective Date / /	Group No 18113
Full Time Hire Date / /	Sublocation

Check One (**Enrollees can change plans only during open enrollment.)

- New Hire
- Open Enrollment
- Change Dental Plans**
- COBRA
- Add/Delete Dependent
- Terminate Employee Coverage
- Spouse Employment Change
- Marital Change
- Other _____

Indicate qualifying date:
 / / (Month) / / (Day) / / (Year)

COBRA Enrollment Only

- Please indicate qualifying event:
- Termination
 - Reduction in Hours
 - Divorce
 - Widowed/Surviving Dependent
 - Dependent Child No Longer Eligible

Indicate qualifying date:
 / / (Month) / / (Day) / / (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____
(Last, First)

Mailing Address: _____
(Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: _____
(Month) (Day) (Year)

Name of Employer/Group E A S I Location _____

Marital Status: Single Married Gender: Male Female Phone # (____) _____ - _____

Do you have dependent children? Yes No Are you or your dependents covered under another dental plan? Yes No

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth:			
Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____/_____/_____ <small>(Month) (Day) (Year)</small>			

- I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.
- I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____

Date _____

Plan Benefit Highlights for: EASI
Group No: 18113



Effective Date: 1/1/2021

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic and Preventive (D & P) and Orthodontics?	\$50 per person / \$150 per family each calendar year Yes			
Maximums D & P counts toward maximum?	\$1,500 per person per calendar year Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits 12 months	Prosthodontics 12 months	Orthodontics 24 months
Benefits and Covered Services*	Delta Dental PPO dentists**		Non-Delta Dental PPO dentists**	
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %		100 %	
Basic Services Fillings and simple tooth extractions	80 %		80 %	
Endodontics (root canals) Covered Under Basic Services	80 %		80 %	
Non-Surgical Periodontics (non-surgical gum treatment) Covered Under Basic Services	80 %		80 %	
Surgical Periodontics (surgical gum treatment) Covered Under Major Services	50 %		50 %	
Oral Surgery Covered Under Major Services	50 %		50 %	
Major Services Crowns, inlays, onlays and cast restorations, denture reline/rebase and repair	50 %		50 %	
Prosthodontics Bridges and dentures	50 %		50 %	
Orthodontic Benefits Dependent childrento age 19	50 %		50 %	
Orthodontic Maximums	\$1,000 Lifetime		\$1,000 Lifetime	
Rates are effective 1/1/2021 – 12/31/2021	Employee Only		\$41.92	
	Employee & 1 Dependent		\$81.93	
	Employee & Family		\$120.41	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.
 ** Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the 90th percentile for non-Delta Dental dentists.

Delta Dental Insurance Company 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009	Customer Service 800-521-2651	Claims Address P.O. Box 1809 Alpharetta, GA 30023-1809
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.