



**DELTA DENTAL PLAN OF NEW HAMPSHIRE, INC.  
PATRIOT HEALTHCARE SIGNATURE PLUS PLAN  
DENTAL CONTRACT APPLICATION**

Northeast Delta Dental  
One Delta Drive  
PO Box 2002  
Concord, NH 03302-2002  
800-537-1715  
www.nedelta.com

PLEASE TYPE OR PRINT LEGIBLY — IN BLUE OR BLACK INK ONLY

GROUP NAME \_\_\_\_\_ GROUP # 19000 - \_\_\_\_\_

	Option I <input type="checkbox"/>	Option II <input type="checkbox"/>
<b>Diagnostic and Preventive</b>		
<b>Diagnostic</b> Evaluations - once in a 6-month period; X-rays (Complete series or panoramic film) once in a 3-year period; Bitewing x-rays once in a 12-month period; X-rays of individual teeth as necessary  <b>Preventive</b> Cleanings once in a 6-month period; Fluoride once in a 12-month period to age 19; Space maintainers to age 16; Sealant application to permanent molars, once in a lifetime per tooth, for children to age 15	Covered at 100%	Covered at 100%
<b>Deductible for Basic, Major, and Orthodontics</b>	\$250 per person/ \$750 per family per calendar year	\$500 per person/ \$1,500 per family per calendar year
<b>Basic</b>		
<b>Restorative</b> Amalgam (silver) fillings; Composite (white) fillings  <b>Oral Surgery</b> Surgical and routine extractions  <b>Endodontics</b> Root canal therapy  <b>Periodontics</b> Periodontal maintenance (cleaning): only one cleaning is covered in a 6-month period; this can be routine or periodontal, but not both  <b>Treatment of gum disease</b>  <b>Denture Repair</b> Repair of a removable denture to its original condition; Emergency palliative treatment	Covered at 100% after deductible	Covered at 100% after deductible
<b>Major</b>		
<b>Prosthodontics</b> Removable and fixed partial dentures (bridge); Complete dentures; Rebase and reline (dentures); Crowns; Onlays; Implants	Covered at 100% after deductible	Covered at 100% after deductible
<b>Orthodontics</b>		
<b>Orthodontics</b> Correction of crooked teeth for adults and children	Covered at 100% after deductible	Covered at 100% after deductible
	Employee Only Employee & Spouse Employee & Children Family	\$29.54 \$57.28 \$69.62 \$104.44
		\$17.67 \$33.54 \$45.83 \$66.66
<b>Benefit Maximum</b>	\$2,500 per person per calendar year	\$2,500 per person per calendar year

Benefit percentages shown are based upon the actual charge submitted to a maximum of the Participating Dentist's approved fees, or Delta Dental's allowance for Nonparticipating Dentists.

Name of Business: \_\_\_\_\_

By: **X** \_\_\_\_\_  
(Duly Authorized Signature)

By: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Name: **Thomas Raffio**

Title: **President & CEO**

Date: \_\_\_\_\_