DMS DENTAL PLAN 126 ENROLLMENT FORM
for
City of Chelsea

Effective Date: _____ Date of Hire: ___/___/___ Date of Birth ___/___/___

Last Name: _____ First: _____ Initial: ___

Street: _____ City: _____

State: _____ Zip Code: _____ Home Phone (_____) _____ Sex M / F

Social Security #_____ Marital Status: _____

I apply for coverage on:

____myself only ____ myself +one dependents (spouse/child) _____ myself and eligible dependents

Last Name (if different)	Sex M or F	Date of Birth	Last Name (if different)	Sex M or F	Date of Birth
2. Spouse			**5.**		
3. Child			**6.**		
4.			**7.**		

Please check option

____ DMS Dental (Network Option) Dental Office Selected: _____
(All dependents are assigned to the same office)

I hereby authorize payroll deductions from my earnings for any contribution required. This authorization remains in effect until revoked by me in writing.

Patient Privacy Statement

In accordance with recent Federal and State Laws regarding privacy or patient's records and information, please be advised that we will not disclose your personal health information (PHI) to anyone with out your authorization or as otherwise permitted or required by law.

Employee Signature: _____ Date: ___/___/___

I agree to stay on the dental program for a minimum of one year (the exception being termination of employment)

Please call DMS Dental at 800-456-8715 with any questions.

DMS Dental Plan 126 Overview

City of Chelsea

TYPES OF DENTAL EXPENSES	DMS Network	
Deductible	None	
Calendar year max	None	
Dentist Availability	DMS Network	
Co Payment	$10 per office visit	
PREVENTIVE Oral Prophylaxis-cleanings Fluoride Treatment Sealants Routine exams Diagnostic x-rays	100%	
BASIC Restorative services -Amalgam	100%	
MAJOR Periodontics -Treatment of gum disease Endodontics - Pulpal therapy and root canals Oral surgery and surgical extractions Crowns, inlays and onlays (Jackets) Prosthetics -Bridges -Partial and complete dentures Space Maintainers	50%	
Orthodontics -Braces-standard 24 month treatment	Discounted Service	
Rates	Monthly Cost	48 weekly deductions
Employee only	$22.00	$5.50
Employee plus one dependent	$43.40	$10.85
Employee and Family	$63.60	$15.90
THIS IS A BRIEF OVERVIEW-SEE PLAN DESCRIPTION FOR LIMITATIONS AND EXCLUSIONS CONTACT DMS DENTAL AT 1-800-456-8715 IF YOU HAVE ANY QUESTIONS		

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