SEANC DENTAL ENROLLMENT FORM

– underwritten by MetLife Insurance

Effective Date: _____ *(for SEANC use only)*

You must be a member of SEANC to enroll.

For more information on becoming a member call 1-800-222-2758 or visit www.seanc.org

Social Security Number: - -	SEANC Member #:	Department / Agency:
Member Name: (**Please Print**) First Middle Last		
Home Address:		
Contact Information: Home: Office:	Cell: Email: @	
Marital Status: ❑ Single ☐ Widowed ❑ Married ☐ Divorced ❑ Domestic Partnership	Sex: ❑ Male ❑ Female	Date of Birth (mm/dd/yy): / /

Coverage Request Data: I have received and read a copy of my group announcement of the dental plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below. **I request the following dental coverage for a period of twelve months. I authorize SEANC to deduct my insurance premium on a monthly basis. Select Plan Option & Coverage Level below.**

Standard Plan Option:		**High Plan Option:**	
❑ Member Only	$21.00	❑ Member Only	$46.05
❑ Member plus Child*	$40.65	❑ Member plus Child*	$88.63
❑ Member plus Spouse*	$42.35	❑ Member plus Spouse*	$92.38
❑ Member plus Child(ren)*	$51.78	❑ Member plus Child(ren)*	$112.02
❑ Member plus Family*	$72.50	❑ Member plus Family*	$163.10

*The "**family**" in addition to the member must either be a spouse, domestic partner or a dependent child or dependent family member. Definitions - "**Domestic Partner**": Prior to the enrollment of MetLife coverage; 1) Partners have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations which has existed for at least 6 months, 2) have shared the same residence for at least six months, and both partners are 18 years of age or older. "**Dependent**": Anyone the member claims as a dependent for federal income tax purposes.

List All Eligible Family Members Below (*if electing dependent coverage*):

	First Name	Last Name	Birth Date	F/T Student?	Sex
Spouse/Partner:			/ /	N/A	☐M ☐F
Child			/ /	☐Yes ☐No	☐M ☐F
Child			/ /	☐Yes ☐No	☐M ☐F
Child			/ /	☐Yes ☐No	☐M ☐F

Your Signature: _____ Date _____

Please retain a copy for your records, and return completed form to SEANC.

Forms may be faxed to the SEANC office: 919-829-5829 or 800-296-4999

or mailed to: SEANC / Attn: Insurance Department / PO Drawer 27727 / Raleigh, NC 27611

MetLife Preferred Dentist Program (PDP)

Product Name: SEANC Standard and High Option Dental Plan
Member Services: 1-800-942-0854, 8:00 a.m. to 11:00 p.m. ET Monday through Friday
Web Address: www.metlife.com/dental

Benefits	Standard Option	High Option
Annual Deductible (In & Out of Network)	$25 Individual Deductible	$50 Individual Deductible
Preventive	**100%, no deductible**	**100%, no deductible**
Basic	**70%, after deductible**	**80%, after deductible**
Major	**0%**	**50%, after deductible**
Orthodontia	**0%**	**50%**
Annual Maximum	**$1,250**	**$3,000**
Lifetime Orthodontia Maximum	$0	$1,500

*MetLife's Preferred Dentist Program allows you to select from a network of dentists who have agreed to charge negotiated fees for covered services. You may still elect to receive services from a non network dentist at the benefit coverage listed above. However, these dentists have not agreed to the negotiated fees, so you may have a higher out of pocket cost.

**A Pretreatment estimates is recommended for expenses over $300.

Frequency/Plan Limitations	Standard Option	High Option
Child Age Student	25	25
Child Age Non-Student	19	19
Child Sealants	yes	yes
Child Sealants Age	19	19
Adult Bitewing Limitation	1x per year	1x per year
Child Bitewing Limitation	2x per year	2x per year
Fullmouth X-Rays	once in 5 years	once in 5 years
Fluoride Treatment To Age	14	14
Fluoride Treatment Frequency	1x per year	1x per year
Periodic Exam Limit	2x per year	2x per year
Prophylaxis Benefit Limits	2x per year	2x per year
Periodontal Maintenance (combined with prophylaxis)	4x per year	4x per year
Pre-Existing Condition Excluded*	No	No
Orthodontia Covered	No	Yes
Preauthorization	Yes	Yes
Denture and Bridgework Replacement	N/A	Every 7 years
Dental Implants	N/A	(Approval Required) Every 7 years
Filling Replacement	As Needed	As Needed
In Network Charge	Negotiated Fee	Negotiated Fee
Out of Network Charge	90th Percentile of Reasonable & Customary Charges	90th Percentile of Reasonable & Customary Charges

** Missing Teeth and Existing Dentures*