SEANC DENTAL ENROLLMENT FORM – underwritten by MetLife Insurance

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

These rates are effective January 1 - December 31, 2016

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

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

Forms may be faxed to the SEANC office: 919-792-3321

or mailed to: SEANC / Attn: Insurance Department / 1621 Midtown Place / Raleigh, NC 27609

Social Security Number: - -	SEANC Member #:	Department / Agency:
Member Name: (**Please Print**) First Middle Last		
Home Address:		
Contact Information: Home: Cell: Office: Email: @		
Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Domestic Partnership ❑ Divorced	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:		**Network Incentive Option:**		**High Plan Option:**	
❑ Member Only	$22.53	❑ Member Only	$28.33	❑ Member Only	$53.59
❑ Member plus Child*	$43.61	❑ Member plus Child*	$54.84	❑ Member plus Child*	$106.82
❑ Member plus Spouse*	$45.44	❑ Member plus Spouse*	$57.13	❑ Member plus Spouse*	$107.50
❑ Member plus Child(ren)*	$55.56	❑ Member plus Child(ren)*	$69.84	❑ Member plus Child(ren)*	$139.41
❑ Member plus Family*	$77.79	❑ Member plus Family*	$97.79	❑ Member plus Family*	$198.22

*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

I, the undersigned, hereby authorize my employer to deduct premiums for the SEANC insurance identified above from my wages/pension on a monthly basis, in such amounts as are currently established pursuant to the SEANC insurance contract with the provider, or in such adjusted amounts as may be established by SEANC and the provider by contract subsequent to the date of this authorization. This authorization shall continue until cancelled by me by written notice to the SEANC Central Office.

Your Signature:_____Date _____

	High Option Plan	Network Incentive Option	Standard Option Plan
Annual Maximum Benefit	**$5,000**	**In - $1,500 Out - $1,250**	**$1,250**
Orthodontia Lifetime Maximum	**$5,000**	**Not Covered**	**Not Covered**
Deductible (Individual)	**$50**	**$25**	**$25**
Deductible (Family)	**$150**	**$75**	**$75**
Type A: Preventive Services	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Preventive Co-Insurance	**100%**	**In - 100% Out – 80%**	**100%**
Routine Exams	2 per calendar year	2 per calendar year	2 per calendar year
Teeth Cleaning	2 per calendar year	2 per calendar year	2 per calendar year
Fluoride Treatments	1 per calendar year to age 14	1 per calendar year to age 14	1 per calendar year to age 14
Full Mouth X-rays	Once every 5 years (Full Mouth and Panoramic).	Once every 5 years (Full Mouth and Panoramic).	Once every 5 years (Full Mouth and Panoramic).
Bitewing X-rays	once per calendar year for adults/ twice per calendar year for children.	once per calendar year for adults/ twice per calendar year for children.	once per calendar year for adults/ twice per calendar year for children.
Type B: Basic Services	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Basic Co-Insurance	**80%**	**In – 80% Out - 60%**	**70%**
Sealants	1 application of sealant material for each non-restored permanent 1st and 2nd molar tooth of a dependent child to age 19, once every 60 months.	1 application of sealant material for each non-restored permanent 1st and 2nd molar tooth of a dependent child to age 19, once every 60 months.	1 application of sealant material for each non-restored permanent 1st and 2nd molar tooth of a dependent child to age 19, once every 60 months.
Space maintainers	One space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 14.	One space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 14.	One space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 14.
Simple Extractions	Covered	Covered	Not Covered
Routine Fillings	Covered	Covered	Covered
Pulp Capping/pulpal therapy	Covered	Covered	Covered
Periodontal maintenance	Limited to 4 times in any year less the number of teeth cleanings received during a 12 month period.	Limited to 4 times in any year less the number of teeth cleanings received during a 12 month period.	Limited to 4 times in any year less the number of teeth cleanings received during a 12 month period.
Palliative Care	Covered	Covered	Covered
Type C: Major Services	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Major Co-Insurance	**50%**	**In – 50% Out – 20%**	**0% Not Covered**
Endodontics	Covered	Covered	Not Covered
Repairs & Recements	Once in 12 consecutive months	Once in 12 consecutive months	Not Covered
Adjustment of Dentures	Once in 12 consecutive months	Once in 12 consecutive months	Not Covered
Surgical Extractions	Covered	Covered	Not Covered
Periodontal Scaling and Root Planing	Once per quadrant in any 24 month period	Once per quadrant in any 24 month period	Not Covered
Root Canal Treatment	Once per tooth in a 24 month period	Once per tooth in a 24 month period	Not Covered
Periodontal Surgery	Once per quadrant every 36 months	Once per quadrant every 36 months	Not Covered
Oral Surgery – Other/Surgical	Covered	Covered	Not Covered
Anesthesia	Covered	Covered	Not Covered
Bridges/Dentures	*Initial installation of fixed bridgework *Initial installation of partial or full removable dentures *Immediate denture replacement: 12 months *Dentures and Bridgework replacement: Frequency limit is once in 7 years.	*Initial installation of fixed bridgework *Initial installation of partial or full removable dentures *Immediate denture replacement: 12 months *Dentures and Bridgework replacement: Frequency limit is once in 7 years.	Not Covered
Crowns/Inlays/Onlays	*Initial installation of crowns, inlays, and onlays (cast restorations): Once in 60 consecutive months * Crown replacement: Frequency limit is once in 7 years.	*Initial installation of crowns, inlays, and onlays (cast restorations): Once in 60 consecutive months * Crown replacement: Frequency limit is once in 7 years.	Not Covered
Dental Implants	Replacements once in 7 years. (Approval Required)	Replacements once in 7 years. (Approval Required)	Not Covered
Relines and Rebases to Dentures	One per 36 months (min. is 6 months after initial installation).	One per 36 months (min. is 6 months after initial installation).	Not Covered
Harmful Habit appliance	Covered	Not Covered	Not Covered
Type D: Orthodontia	**High Option Plan**	**Network Incentive Option**	**Standard Option Plan**
Orthodontia Co-Insurance	**50% (child up to age 19, student up to age 25)**	**0% Not Covered**	**0% Not Covered**

* Please refer to the Plan Certificate for a detailed description of the dental plan
* NOTE: The Network Incentive Option is not available to residents in MS, TX, LA, or M

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