DENTAL ENROLLMENT FORM FOR MTA MEMBERS

MTA BENEFITS Massachusetts Teachers Association

AMBA

1.) Complete the application by following Steps 1 - 5.
2.) **Return the application to AMBA 3913 Hartzdale Dr, Suite 1300 Camp Hill, PA 17011.**
3.) **Applications received by the 20th of a month will become effective the 1st of the following month.**
Be sure to include your payment for insurance (annual or 1st month)

STEP 1: TELL US ABOUT YOURSELF

Name: Address:	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security Number** (Required)**:**
Phone Number: (_____) _____-_____	**Email Address:**	**MTA Membership Number:**	

STEP 2: SELECT YOUR COVERAGE	**MONTHLY DENTAL RATE**	**ANNUAL DENTAL RATE**
Individual	☐ $70.00	☐ $840.00
Two Party (applicant plus one)	☐ $129.00	☐ $1,548.00
Family (applicant plus two or more)	☐ $195.00	☐ $2,340.00

STEP 3: SPOUSE OR DEPENDENT COVERAGE INFORMATION: Dependent children up to age 26 are eligible for coverage.

First Name: _____ **Last Name:** _____	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security #** (Required)**:**
First Name: _____ **Last Name:** _____	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security #** (Required)**:**

STEP 4: PAYMENT CHOICE: *(Please select one)*

☐ **Convenient Monthly Bank Draft**
Make your check payable to AMBA for your first month's premium and complete account information.
Routing Number (9 digit): __ __ __ __ __ __ __ __ __ Account Number: _____

I (we) authorize and request PISI to initiate electronic debit entries to my (our) account indicated on this form in the financial institution named on this form ("BANK"). I (we) authorize and request BANK to honor the debit entries initiated by AMBA and debit these charges to that account. This authorization will remain in effect until all amounts owed related to the contract are paid in full, or until I (we) cancel this authorization. To cancel this monthly withdrawal I (we) must notify AMBA and BANK in writing 60 days in advance to give AMBA and BANK a reasonable opportunity to act. Cancellation of this electronic debit authorization does not cancel the terms of the Dental contract, I am agreeing to pay the full annual Dental premium. I understand that the funds will be withdrawn on the 10th day of each month and that it is my responsibility to ensure sufficient funds are in my account at that time. If the 10th of the month falls on a weekend or holiday, AMBA will initiate a debit entry on the next business day. If more than 2 withdrawals in a 12 month period are denied for any reason I understand I risk cancellation of my Dental Benefits.

☐ **Annual Payment By Check**: Please make your check payable to "AMBA".

☐ **Annual Payment By Credit Card.**
Cardholder Number: _____
Expiration Date (mm/yy): _____ CVV code (3-digits on back): _____

STEP 5: PLEASE READ AND SIGN BELOW

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading information concerning any fact material thereto commits a fradulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I hereby apply for the coverage indicated, and understand that the premium payment is for 12 months of coverage and is not refundable for any reason. If I do not renew my contract at the end of the 12 months, I cannot re-enroll for 36 months. I further understand that my enrollment is subject to receipt of payment in the correct amount. If a check is returned for any reason, a $20.00 fee will be charged.

_____ _____

Please sign as acknowledgment of above **Date**

For office use only Eff Date: _____ Cust ID: _____ DW: _____ VW: _____ APPID: _____

MTA BENEFITS
Massachusetts Teachers Association

UNITED CONCORDIA
Insuring America's Dental Health

Massachusetts Teachers Association

Endorsed United Concordia Dental Plan (PPO)[1]

Administrator: **AMBA**
3913 Hartzdale Dr, Suite 1300 • Camp Hill, PA 17011 · Toll Free 800.382.1352

Benefit Categories	Network Dentist[2]	Non-Network Dentist[2]
Class I – Diagnostic/Preventive Services		
Routine Examinations and Routine Cleanings - 2 in 12 consecutive months	100% (of MAC[2])	80% (of MAC[2])
Routine Bitewing X-rays - 2 in 12 consecutive months **Full Mouth X-rays** - once every 36 months		
Fluoride Treatments - 2 in 12 consecutive months		
Sealants - once every 36 months		
Palliative Emergency Treatments		
Class II – Basic Services		
Minor Restorations - amalgams/synthetic fillings	60% (of MAC[2])	50% (of MAC[2])
Endodontics - root canal therapy		
Simple Extractions		
Anesthesia Services		
Class III – Major Services		
Periodontics - treatment of gum disease	50% (of MAC[2])	40% (of MAC[2])
Complex Oral Surgery		
Dentures, Bridges & Crowns Time limits may apply for replacements and repairs		
Repair of Full or Partial Dentures		
Program Deductibles and Maximums		
Contract Year Deductible - (excluding Class I Services)	$50 Per Person	
Contract Year Maximum - (excluding Class I Services)	$1,900 Per Person	

Annual Premiums

Individual	**$840**
Two-Party	**$1,548**
Family	**$2,340**

For 12 Consecutive Months of Coverage

MONTHLY PAYMENTS ALSO AVAILABLE

NETWORK DENTISTS[3]
- No Claim Forms
- Over **40%** Average Savings Off Provider Fees
- Payment Directly to Doctor
- **Amended providers - discounts on non-covered services**

NON-NETWORK DENTISTS[3]
- Freedom of Choice
- Payment Directly to Patient
- All eligible plan services covered – but at a slightly lower percentage of MAC[2].

CALL 1.800.332.0366
OR VISIT
www.ucci.com
FOR A LIST OF PARTICIPATING DENTISTS IN THE **ADVANTAGE PLUS NETWORK**

[1] The United Concordia Dental Plan is underwritten by United Concordia Life and Health Insurance Company. The Plan is available to active and retired MTA members and their dependents. Dependents include your spouse, unmarried dependent children under age 26 or to any age if incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon you for maintenance and support.

[2] The listed percentages represent the portion of United Concordia's maximum allowable charge (MAC) for which the Plan will be responsible. The member will be responsible for the balance including any difference between United Concordia's MAC and the fee charged by a non-network dentist. Network dentists accept United Concordia's MAC as payment in full for covered services, limiting out-of-pocket costs to coinsurances, deductibles and amounts exceeding the annual maximum. United Concordia's standard exclusions and limitations apply.
Payment is limited to $1,900 per person per contract year. Each contract year is from the effective date of your contract until the end of the 12th month after your effective date. Each contract year members are required to meet the first $50 for services covered under the Class II and Class III services categories, as indicated above. Class I services are exempt from the deductible. There is only one deductible per person in a contract year.

[3] Based on United Concordia internal research and reports, January 2019.