ELECTRONIC APPLICATION INSTRUCTIONS:

1. To apply for dental coverage, please complete this application.

2. Check the coverage you desire: individual; two-party (member and spouse or member and child); or family (member plus two or more dependents). Unmarried dependent children can be enrolled up to age 26, and disabled dependents to any age. If enrolling a disabled dependent age 26 or older, please call 800.382.1352 for a dependent certification form which must be completed and returned with your application.

ANNUAL DENTAL PREMIUMS	
Individual	**$840**
Two-party	**$1,548**
Family	**$2,340**

3. Payment options are: full annual premium payment by MasterCard, Visa or Discover credit cards; or the monthly withdrawal from your checking account*.

   **If you choose the "MONTHLY WITHDRAWAL" option for the dental coverage you are agreeing to pay the full annual premium. Please complete the enclosed Authorization for Monthly Withdrawal Form.*

4. Once you have completed the application, save the document to your computer.

5. **Email the completed application to info@pisibenefits.com**. If your application and payment are received at AMBA by the 20th of the current month, the coverage will become effective the 1st of the following month. You will receive an ID card from United Concordia. To confirm your effective date, please call 800.382.1352.

For further assistance on applying online, please call 800.382.1352

Important Notice:

These benefits are available to active and retired dues-paying MTA members and their spouses. You must include your MTA membership number to enroll and make sure your dues payment remains current while enrolled in this plan.

MTA BENEFITS
Massachusetts Teachers Association

MASSACHUSETTS TEACHERS ASSOCIATION

Dental Application

UNITED CONCORDIA
Insuring America's Dental Health

TYPE BELOW TO COMPLETE ALL FIELDS.

Please see other side on how to apply . . .

MTA MEMBER- APPLICANT

MTA Membership Number

Social Security Number	*Last Name*	*First*	*M.I.*
_ _			

Street Address	*Telephone*
	( )

City	*State*	*Zip*	*Sex*	*Birth Date (Mo/Day/Yr)*
			☐M ☐F	/ /

Email Address ☐ ***YES*** *I would like to receive Paperless correspondence and/or Renewal Invoices via email.*

COVERAGE DESIRED & ANNUAL PREMIUMS *(Please ✔ one)*

Premiums include a Third Party Administration fee.

☐ Individual (Applicant Only) **$840**	☐ Two-Party (Applicant Plus One) **$1,548** *enter information below*	☐ Family (Applicant Plus Two or More) **$2,340** *enter information below*

FAMILY MEMBERS - DEPENDENTS

	Social Security No.	*Last Name*	*First*	*M.I.*	*Sex M/F*	*Birth Date Mo/Day/Yr*	*Disabled Yes/No*
Spouse					F		N
→ **For disabled dependent children age 26 or older call 1-800-382-1352 for a Dependent Certification form.** ←							
Child					F		N
Child					F		N
Child					F		N

PAYMENT METHOD

ENTER CREDIT CARD INFORMATION BELOW:

Please check one:

☐ ***MasterCard***
☐ ***Visa***
☐ ***Discover***

Card No. _____ *Exp. Date* _____ *CVV Code** _____

*Three digit code on back of card

_____
Cardholder's Name, as it appears on Credit Card

_____
Cardholder's Address (if different from applicant)

X _____ X _____

Signature (for Credit Card authorization only) *Date*

Important—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 fraudulent 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.

X _____ X _____

Applicant's Signature ***Date***

AMBA
3913 Hartzdale Dr. Suite 1300
Camp Hill, PA 17011
1-800-382-1352

MTA BENEFITS
Massachusetts Teachers Association

AUTHORIZATION FOR MONTHLY WITHDRAWAL

Dear MTA Member:

The monthly withdrawal from your checking account is available for the dental premium. The monthly withdrawal option cannot be applied to a credit card.

- To enroll in the AMBA monthly withdrawal option, complete, sign and mail the bottom half of this form. **You must include your dental application or renewal notice.**

	Monthly Rate	ANNUAL TOTALS
INDIVIDUAL	$ 70.00	$ **840.00**
TWO-PARTY	$129.00	$ **1,548.00**
FAMILY	$195.00	$**2,340.00**

- **The first month's payment will be deducted from your checking account at the time your application is processed.** For the remaining 11 months of your contract AMBA will debit your account. You will **not** receive monthly bills.
- AMBA will request a transfer of payment from your bank account on the **10th day of each month.** If the 10th of the month falls on a weekend or holiday, the transfer will take place the next business day.
- Next year, at time of renewal, you will be notified of any changes in the plan benefits or cost but the Monthly Withdrawal will automatically continue; unless you choose to pay in full or advise us of cancellation.

Please keep a copy of this agreement for your records.

I (we) authorize and request AMBA 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 PISI 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 understand 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.

Bank Name: _____

9-Digit Routing Number: _____

Checking Account Number: _____

Name on Checking Account _____ **Date** _____

Signature _____

For Office use only:

MTA **#**_____ **M**_____ **W**_____