MTA BENEFITS
Massachusetts Teachers Association

Dental Application

UNITED CONCORDIA
Insuring America's Dental Health

PLEASE PRINT CLEARLY.

Please see other side for application instructions...

MTA MEMBER- APPLICANT

MTA Membership Number			
Social Security Number – –	Last Name	First	M.I.
Street Address			Telephone ( )
City	State	Zip	Sex ☐M ☐F
Birth Date (Mo/Day/Yr) / /			
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)	☐ Two-Party (Applicant Plus One)	☐ Family (Applicant Plus Two or More)
$726	**$1,344** *enter information below*	**$2,037** *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							
→ **For disabled dependent children age 26 or older call 1-800-382-1352 for a Dependent Certification form.** ←							
Child							
Child							
Child							

PAYMENT METHOD

☐ ***Enclosed Check/Money Order*** *(please make check payable to "PISI")*

Credit Card:
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***

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	**$726**
Two-party	**$1,344**
Family	**$2,037**

3. Full annual premiums must be submitted for the type of coverage you choose. Payment options are: check; MasterCard, Visa or Discover credit cards; money order; or monthly withdrawal from your checking account*. **Checks are to be made payable to "PISI"**. A $20.00 fee will be charged for any checks returned due to insufficient funds.

   **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. Mail the fully completed application and your payment using the enclosed postage-paid envelope to: **Professional Insurance Services, Inc., 3913 Hartzdale Dr., Suite 1300, Camp Hill, PA 17011**. If your application and payment are received at PISI by the 20th of the current month, the coverage will become effective the 1st of the following month. You will receive an identification card from United Concordia. To confirm your effective date, 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.

PISI
PROFESSIONAL INSURANCE SERVICES, INC.

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

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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 PISI monthly withdrawal option, complete, sign and mail the bottom half of this form. **You must include your dental application or renewal notice, and your first month's check made payable to "PISI" using the amount shown below**.

	First Month's Check	Eleven Monthly Withdrawals	ANNUAL TOTALS
INDIVIDUAL	$ 60.50	$ 60.50	$ **726.00**
TWO-PARTY	$112.00	$112.00	$ **1,344.00**
FAMILY	$169.75	$169.75	$**2,037.00**

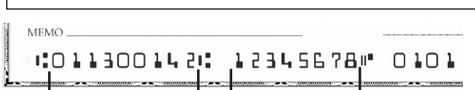
- Your check will pay the first month's premium. For the remaining 11 months of your contract PISI will debit your account. You will **not** receive monthly bills.
- PISI will request a transfer of payment from your bank account on the **10th day of each month.** If the 10th of the month falls on a weekend or holiday, the transfer will take place on 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.

TEAR HERE

Keep top portion for your records. A copy of the agreement is on the back.

Detach and return this portion with your **dental application** *or* **renewal notice, and first month's check made payable to "PISI".**

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 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 PISI and BANK in writing 60 days in advance to give PISI 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, PISI 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 _____

Anyone else whose signature is required to withdraw funds from this account must sign here: _____ **Date** _____

Policyholder's Name (if different from above) _____

MTA

First Month's Payment
Individual: $60.50
Two-Party: $112.00
Family: $169.75

For Office use only:

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

Below is a copy of the Agreement you have entered into with Professional Insurance Services, Inc. for the purchase of United Concordia dental insurance. Please keep this copy for future reference.

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 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 PISI and BANK in writing 60 days in advance to give PISI 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, PISI 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.

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UNITED CONCORDIA
Insuring America's Dental Health

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Concordia Preferred (PPO) Dental Plan[1]

Administrator: PROFESSIONAL INSURANCE SERVICES, INC.

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 - Two in 12 consecutive months	100% (of MAC[2])	80% (of MAC[2])
Routine Bitewing X-rays - Two in 12 consecutive months/Full Mouth X-rays - Once every 36 months.		
Fluoride Treatments -Two 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		
Inlays, Onlays, Crowns (Caps)	50% (of MAC[2])	40% (of MAC[2])
Periodontics - Treatment of gum disease		
Complex Oral Surgery		
Dentures and Bridges		
Repair of Full or Partial Dentures		
Program Deductibles and Maximums		
Contract Year Deductible (excludes Class I)	$50 Per Person	
Contract Year Program Maximum (excludes Class I)	$1,900 Per Person	

Annual Premiums

Individual	$726
Two-Party	$1,344
Family	$2,037

For 12 consecutive months of coverage

NETWORK DENTISTS[3]

- No claim forms
- Over 40% average savings off provider fees
- Payment directly to doctor
- Locations available nationwide

NON-NETWORK DENTISTS[3]

- Freedom of choice
- Payment directly to patient
- All eligible plan services covered-but at a slightly lower percentage.

Call 800.382.1352
or visit the website at
www.ucci.com
to find a list of
participating dentists in the
Advange 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.