DELTA DENTAL

Census Information

Client Information

Company ______

Phone # ______ Fax # ______

Nature of Business ______ SIC ______

Street ______ City ______

State ______ Zip ______

Other Locations

Please include city, state and # of employees

______

______

______

No. of Employees

Benefits Eligible Employees ______

Individual ______

Individual plus 1 dependent ______

Family ______

Current Coverage

Currently offer dental ☐ Yes ☐ No
(if yes, please complete this section)

Current Carrier ______

Policy Renewal Date ______ Years Covered______

3 Tier Rate Structure ☐ Yes ☐ No

Monthly Contributions Individual $______ Family $______

Coverage Percents

Preventative ______%
Basic ______%
Major ______%
Deductible $______
Maximum $______
Orthodontic ______%
Separate Orthodontic Maximum $______

Rates

Current
Individual $______
Individual +1 dependent $______
Family $______

Renewal
Individual $______
Individual +1 dependent $______
Family $______

Please attach a current benefits booklet and claim and premium history for the last 2 years if they're available.

Proposed Delta Coverage

Proposed Effective Date: ______

Coverage	Option 1	Option 2	Option 3
Preventive	%	%	%
Basic	%	%	%
Major	%	%	%
Deductible	$	$	$
Maximum	$	$	$
Orthodontic	%	%	%
Ortho Maximum	$	$	$

Please fax to Delta Dental of Massachusetts, Sales Department at (617) 886-1129

Completed by: ______ Title: ______