DENTAL PAYROLL DEDUCTION FORM - EFFECTIVE JANUARY 1, 2020

You must also complete the Universal Dental Enrollment Form for Delta Dental / Eastern Dental (Healthplex). Enrollment forms can be obtained from your Personnel Office.

NOTE: TO DETERMINE YOUR DENTIST'S PARTICIPATING STATUS IN THE DELTA DENTAL PROGRAMS, CHECK WITH YOUR DENTIST DIRECTLY OR ONLINE AT www.deltadentalnj.com OR BY CALLING DELTA DENTAL AT **1-800-DELTA-OK** AND PROVIDE THE GROUP NUMBERS LISTED BELOW TO THE REPRESENTATIVE.

Please select only ONE option from the plans listed below:

DELTA DENTAL — *Semi-Monthly Deduction*

Group # 3238-0005(County); 3238-0007 (Social Services)

_____ Single - **Premier** - 50/50% ***Core Plan****, $50% UCR reimbursement, any dentist, $2000 annual max* ..... **$ *****

***** Under Chapter 78 mandates, you will be assessed a % of the monthly County Liability of $14.50 based on the Single Coverage salary guide.*****

The Dental plans below require, in addition to the above assessment, the following deductions:

DELTA DENTAL — *Semi-Monthly Deduction*

Group # 3238-0006 (County); 3238-0008 (Social Services)

_____ Single - **Premier** - 80/20% *80 % UCR reimbursement, any dentist, $2000 annual max*..... $ 6.87

_____ Family - **Premier** - 80/20% *80 % UCR reimbursement, any dentist, $2000 annual max*..... $ 40.90

Group # 3238-6003 (County); 3238-6004 (Social Services)

_____ Single - **Preferred** - 80/20% *80%, select a participating preferred dentist, $2000 annual max*..... $ 3.67

_____ Family - **Preferred** - 80/20% *80%, select a participating preferred dentist, $2000 annual max*..... $ 29.99

Group # 3238-9001(County); 3238-9002 (Social Services)

_____ Single - **DeltaCare Flagship** – *use Plan dentist, most services at no cost or moderate co-pays*.....$ 5.24

_____ Employee + 1 dependent - **DeltaCare Flagship** - *most services no cost or moderate co-pays*..... $ 16.48

_____ Employee + 2 or more dependents - **DeltaCare Flagship** - *most services no cost or moderate co-pay*.....$ 30.21

EASTERN DENTAL (Healthplex) – Dental Center Facilities

Group # GJ2102 (County); GJ2081 (Social Services)

_____ Single - **Dental Centers** - *select dental center, most services are no cost or moderate co-pays*..... $ 5.29

_____ Employee + 1 dependent - **Dental Centers** *select center, no cost or moderate co-pays*..... $ 17.83

_____ Employee+2 or more dependents -**Dental Centers** *select dental center, no cost or moderate co-pay*..... $ 35.01

_____Decline Dental

I hereby authorize the County of Union to deduct from my pay, the appropriate benefit deductions that I have selected. It is understood that the selections I have indicated are for a 12-month period and cannot be altered or changed until the next open enrollment period, tentatively scheduled for December, 2020.

Print Name: _____ SS# _____

Phone Number_____Dept/Div_____

Effective Date:_____

Signature: _____ Date: _____