

City of Chelsea

DMS Dental Enrollment Form

Last Name: _____ First: _____ Initial: _____

Date of Birth: ___/___/___ Date of Hire: ___/___/___

Street: _____ City: _____

State: _____ Zip Code: _____ Home Phone: (____) _____

Sex: M / F

Social Security #: _____ Marital Status: _____

Email Address: _____

(your privacy is important to us and we do not share your email)

I apply for coverage on:

- myself only
 myself + one dependent (spouse/child)
 myself and eligible dependents

List all eligible dependents to be covered:

Last Name (if different)	First Name	Initial	Sex M.or F.	Date of Birth	Last Name	First Name	Initial	Sex M.or F.	Date of Birth
2.	Spouse				5.				
3.	Child				6.				
4.					7.				

DMS Dental Network Plan
 Dental Office Selected: _____
 (all dependents are assigned to the same office)

In accordance with recent Federal and State Laws regarding privacy or patient's records and information, please be advised that we will not disclose your personal health information (PHI) to anyone without your authorization or as otherwise permitted or required by law.

I agree to stay on the dental program for a minimum of one year (the exception being termination of employment).

Employee Signature: _____ Date: ___/___/___

Please call DMS Dental at 800-456-8715 with any questions.

DMS Dental Plan 126 Overview

City of Chelsea

TYPES OF DENTAL EXPENSES	DMS Network	
Deductible	None	
Calendar year max	None	
Dentist Availability	DMS Network	
Co Payment	\$10 per office visit	
PREVENTIVE		
Oral Prophylaxis-cleanings	100%	
Fluoride Treatment	100%	
Sealants	100%	
Routine exams	100%	
Diagnostic x-rays	100%	
BASIC		
Restorative services	100%	
-Amalgam	100%	
MAJOR		
Periodontics	50%	
-Treatment of gum disease	50%	
Endodontics	50%	
-Pulpal therapy and root canals	50%	
Oral surgery and surgical extractions	50%	
Crowns, inlays and onlays (Jackets)	50%	
Prosthetics	50%	
-Bridges	50%	
-Partial and complete dentures	50%	
Space Maintainers	50%	
Orthodontics	Discounted Service	
-Braces-standard 24 month treatment	Discounted Service	
Rates	Monthly Cost	48 weekly deductions
Employee only	\$22.00	\$5.50
Employee plus one dependent	\$43.40	\$10.85
Employee and Family	\$63.60	\$15.90
THIS IS A BRIEF OVERVIEW-SEE PLAN DESCRIPTION FOR LIMITATIONS AND EXCLUSIONS CONTACT DMS DENTAL AT 1-800-456-8715 IF YOU HAVE ANY QUESTIONS		