

## Athens Area School District Memorandum

**To:** Members – Athens Area Education Association  
**From:** Kevin Rimmey, Business Manager *KDR*  
**Re:** Family Dental Option  
**Date:** 2011-2012

As part of the Collective Bargaining Agreement that was approved at the June 2011 School Board meeting, the Athens Area School District is expanding the Dental Insurance coverage in agreement to allow you, as an employee, to add "Family Dental Coverage" at your expense.

The cost for Employee & Family Coverage is: \$ 116.25/month

The cost for Employee Coverage alone is: - 45.95/month

**The Employee cost to add Family Coverage is: \$ 70.30/month**

The total annual cost to the employee for the Family Dental Coverage is \$843.60, which will be divided by the number of pays you will be receiving for the year. That amount will then be deducted from each payroll check.

If you have any questions, please feel free to call me at 888-7766 ext. 4249.

Thank you!

# FAMILY COVERAGE

## Enrollment/ Change Form



One Delta Drive, Mechanicsburg, PA 17055  
 (800) 932-0783  
 TTY/TDD (888) 373-3582  
 www.deltadentalins.com

Please check the applicable box or boxes.

- New enrollment
- COBRA
- Coverage change
- Name change
- Address change
- Change of dependents
- Termination
- Decline Coverage

Please check the applicable box.

- Delta Dental PPO plus Premier

Please check the Delta Dental plan that administers your dental benefits.

- Delta Dental of Pennsylvania
- Delta Dental of New York
- Delta Dental Insurance Company
- Delta Dental of Delaware
- Delta Dental of West Virginia

Primary Enrollee Social Security Number

Last Name

First Name

MI

Date of Birth

Gender  
 Male  
 Female

Alternate Identification Number (if applicable)

Address

(Is this a change of address?)  
 Yes  No

Street

City

State

Zip Code

Group Number

5612

Sublocation

Group Name

Athens Area School District

Change of Coverage

New Coverage:

Former Coverage:

Name Change

From:

To:

Dependent Change

Please check one of the boxes:

Add dependent(s) listed below

Delete dependent(s) listed below

Do you or your dependents have other dental coverage?

Yes  No If yes, please complete the following:

Carrier Name and Address:

Group Number:

Spouse

Children

His Name

MI

Gender

Date of Birth

Social Security Number

His Name	MI	Gender	Date of Birth	Social Security Number
		M	F	
		M	F	
		M	F	
		M	F	
		M	F	
		M	F	

Date of Hire:

Effective Date:

Primary Enrollee Signature

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.