Benefits

For State Employees

David Dearie Insurance

Hi,

Thanks! Here is the application, payroll form and brochure for the insurance you requested. Complete the application and payroll form the best you can and send it to me. I'll check it and email you when I receive it.

You can send it to me either:

By mail: David Dearie, 3001 Jodie Place, Metairie, LA 70002

By fax: 504-717-4808 (faxes come directly to my email, so it is safe)

By email: Scan and send it to dearie@cox.net

Or call me, and I will come pick it up.

Thanks again,

David B. Dearie

David Dearie

504-616-3537 cell

504-717-4808 fax

Passive PPO

Indemnity Dental Insurance

Choose Any Dentist

	Preventative	Basic	Major	Orthodontic
COINSURANCE	Type I	Type II	Type III	Services
	100%	**80%**	**50%**	**50%**

Annual Benefit—Per Person $1,500.00

Benefit Year Deductible, Per Person $50 / Per Family $150

This deductible applies to Type II and III Services

Payment is based upon allowable charges in the area in which service is rendered.

Services provided at a non-contracting provider are paid at the 90th percentile.

To save money, you can choose a dentist that is a member of the Dentemax network, go to www.dentemax.com.

TYPE I - PREVENTATIVE SERVICES - 100%

Including:

- **No waiting period, no deductible**
- Routine Exams
- Prophylaxis (Cleanings-one per 6 months)
- Emergency exams for dental pain (minor procedures)
- Fluoride treatments for dependent children under age 19 (one per 12 months)
- Bitewing X-rays (once per 6 months

TYPE II - BASIC SERVICES - 80%

Including:

- **No waiting period**
- Full mouth or panorex X-rays (1 per 36 months)
- Simple restorative services (fillings)
- Simple extractions
- Sealants for children ages 6-15 (1 per tooth)

TYPE III (MAJOR SERVICES) - 50%

Including:

- **12 month waiting period (takeover provisions apply)**
- Major restorative services (crowns and inlays)
- Prosthetics (bridges, dentures)
- Replacement of prosthodontics, dentures, crowns and inlays
- Denture relines
- Space maintainers
- Oral Surgery
- General anesthesia (for services dentally necessary
- Endodontics/root canal therapy
- Periodontics

ORTHODONTIC SERVICES

- **12 month waiting period**
- $50 separate deductible
- 50% coverage
- $1,000 lifetime maximum benefit
- Children under 19 only

Semi-monthly Premiums:

Louisiana State Employees and Retirees

Employee Only	$12.86
Employee + Spouse	$25.07
Employee + Children	$30.47
Employee + Family	$42.06

For Information or to enroll contact:

David Dearie
dearie@cox.net
(504) 616-3537
www.daviddearieinsurance.com

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DINA Dental Plan™
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478

DINA Dental Plan™
Customer Service: 866-436-3093
dina@fcldental.com

An SED-4 Payroll Deduction form must accompany all applications.

Application/Change Form for Membership and Dental Insurance

Louisiana State Employees and Retirees ~ Passive PPO

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Phone: SSN:	Date of Birth:	Male ☐ Female ☐
Employer:	Agency No.:	Work Phone:
Date of Hire:	Email:	Date of Termination (if cancelling):

Effective Date: _____

Add	☐
Delete	☐
Change	☐
Cancel	☐
Other	☐

Louisiana State Employees and Retirees		
Enrollment Status	Passive PPO Plan	
Employee Only	☐	$25.71
Employee + Spouse	☐	$50.14
Employee + Child/ren	☐	$60.93
Employee + Family	☐	$84.12

Include coverage for the listed dependents. Unmarried children up to age 26 may be covered as a dependent.

Dependents	First, Middle Initial, Last Name	Social Security Number	Date of Birth	Male	Female
Spouse				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐

Do you or any dependents listed above have other dental insurance coverage? Yes ☐ No ☐

Membership in the DINA Dental Plan and dental insurance is requested for all persons named in this application.

Deductions from the applicant's payroll will begin on the next payroll run following the date of this application. If there is a gap between the applicant's effective date and payroll deduction date, DINA requires a payment to be submitted for coverage between the applicant's effective date and first payroll deduction date so that coverage can begin on the first of the month following the date of this application.

Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Applicant's Signature: _____ Date Signed: _____

Agent's Signature: David Dearie DINA Agent # 468

Takeover: Yes ☐ No ☐ Prior Carrier & Expiration Date: _____

Semi-Monthly Payroll Deductions for Louisiana State Employees and Retirees

Payroll Deduction Start Date: _____

Amount of Deduction Per Pay Period: _____

Check the box below that corresponds to your pay structure:

☐ 9 Month ☐ 10 Month ☐ 12 Month

Company Use Only		
Group #	Certificate #	
Mode Premium $	Monthly Premium $	Amount Paid with App $

SED-4 (R 01/12)

First Continental Life & Accident Insurance Company

101 Parklane Blvd, Ste 301, Sugar Land, TX 77478
Customer Service (866) 436-3093
An application for Prepaid or Passive PPO must accompany all SED-4 Forms

State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. Sec. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $_____, monthly rate, from my salary until further notice and remit same to **DINA Dental**.

A TOTAL Semi-Monthly Deduction in the amount of $ _____ represents one half of the total monthly premium required for the coverage(s) detailed below.

The Office of State Uniform Payroll and the employing agency are **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the **employee and the vendor** to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to **both** the vendor **and** his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the ISIS HR payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee **and** the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART CD	YES	NO	125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
Dental (DINA)	23		N	Y	$	**NA**	$	
Dental (DINA)	23	P		Y	$	**PA**		$

	Total Mo. Prem.	$	
PP Begin Date	Total Semi-Mo. **Ineligible**		
	Total Semi-Mo. **Non-Part.**	$	
Date Authorized	Total Semi-Mo. **Part.**		$
By: _____ Employee Signature	**TOTAL SEMI-MONTHLY**		$

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by:

David Dearie — DINA Dental Representative
(866) 436-3093 — Phone
_____ — Date

101 Parklane Blvd, Ste 301, Sugar Land, TX 77478
Address