

DELTA DENTAL OF IDAHO  
P.O. Box 2870  
Boise, ID 83701  
(208) 489-3582 Fax (208) 489-3556

August 25, 2014

kglascoc@co.twin-falls.id.us

Kristina Glascock  
Twin Falls County  
PO Box 126  
Twin Falls, ID 83303

RE: Contract Amendment

Dear Kristina:

Enclosed is your Contract Amendment for changing the married employee enrollment requirement that will be effective on October 1, 2014. I have enclosed the Contract Amendment, which enumerates these specific changes. Please sign the Contract Amendment immediately to avoid possible delay in claims payment, and return to Delta Dental.

Delta Dental is committed to quality service and meeting the needs of our clients. Delta Dental appreciates your business and we hope to continue our win/win partnership. If you should have any questions about the Contract Amendment or your dental benefits, please call your producer or sales representative, Hilary Swidecki at 489-3526.

Sincerely,



Judy Dishner  
Underwriter

Enclosures

cc: Lori Lee Bergsma, Producer, lori@balancedrockinsurance.com  
Hilary Swidecki, Delta Dental

# Contract Amendment

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## Twin Falls County Group #1299

Attached to and forming a part of the Contract to Provide Dental Care benefits between Twin Falls County and Delta Dental of Idaho, Inc.:

Agreement dated October 1, 1999 is hereby amended effective October 1, 2014.

**SECTION I. DECLARATIONS, PARAGRAPH E: ELIGIBILITY (subscriber and dependents) – replace with the following:**

Where two subscribers who are legally married to each other are eligible under the same group or any other dental group of the contractor and/or have dental coverage separately or jointly under any other contractor, they will be enrolled under separate enrollment cards and will receive benefits under a single contract without coordination of benefits under the Delta Dental contract.

Accepted:

DELTA DENTAL OF IDAHO, INC.  
PO Box 2870  
Boise, ID 83701

Twin Falls County

By: 

By: \_\_\_\_\_

Title: President and Chief Executive Officer

Title: \_\_\_\_\_

Date: August 25, 2014

Date: \_\_\_\_\_

**Please sign & return this signature page to Delta Dental immediately to avoid possible delay in claims payment.**