Delta Dental of Minnesota
3560 Delta Dental Drive
Eagan, MN 55122-3166
651-406-5900 or 1-800-328-1188

Master Dental Contract Application
Individually Rated Plans

PART A - COMPANY INFORMATION

Legal Company Name _____
(as it should appear on the contract)

Address _____ Phone ( ) _____

_____ County _____

City _____ State _____ Zip Code _____

Plan Effective Date: _____ Plan Benefit Year: ☐ Calendar ☐ Other: _____

Total number of eligible* employees: _____

*Eligible employees are all employees working _____ or more per week.

Eligibility waiting period for new employees: First of month following: _____ Other: _____

Return to work guidelines: _____ Status change (i.e. part time to full time): _____

Coverage Type: ☐ Employee (EE) Only ☐ EE + 1 ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family

Participation Requirements: ☐ Employee/Dependent: ____% / ____% OR ☐ As Currently Enrolled

Does your company currently have a dental plan? ☐ No ☐ Yes - Name of carrier: _____

Length of coverage: _____

☐ **Medical Lock** (include a copy of most recent medical billing statement).

PART B - DENTAL PROGRAM - PRODUCT/NETWORK

PRODUCT	NETWORK(S)
☐ Comprehensive Standard	☐ Delta Dental PPO (PPO)
☐ Comprehensive Enhanced	☐ Delta Dental Premier (DP)
☐ Other: _____	☐ Other: _____

PART C - PLAN DESIGN

	PPO	DP	OON	DEDUCTIBLE APPLIES
Diagnostic & Preventive Services	%	%	%	
Basic Services	%	%	%	
Endodontics	%	%	%	
Periodontics	%	%	%	
Oral Surgery	%	%	%	
Major Restorative Services	%	%	%	
Prosthetic Repairs and Adjustments	%	%	%	
Prosthetics	%	%	%	
Traditional Orthodontic Plan Services	%	%	%	

☐ Dependent Child Only ☐ Ages 8 through 18 ☐ Other: _____
☐ Adult and Dependent Child ☐ Ages 8 through 99 ☐ Other: _____

	PPO	DP	OON
ANNUAL DEDUCTIBLES:			
Individual Maximum:	$	$	$
Family Maximum:	$	$	$
MAXIMUMS:			
Annual Per Person:	$	$	$
Lifetime Orthodontics:	**$**	**$**	**$**

OPEN ENROLLMENTS:
☐ Annual ☐ None ☐ Other: _____

☐ **PLAN I – TRADITIONAL ORTHODONTIC PLAN SERVICES**
Does the prior dental plan have orthodontic coverage?
☐ Yes ☐ No

☐ **PLAN II – ORTHODONTIC DISCOUNT PLAN ***
☐ Group Plan – All enrolled Eligible Employees
☐ Voluntary Plan – Individually Enrolled Employees
***SEPARATE FROM DENTAL PLAN BENEFITS – NOT AVAILABLE IF CHOOSING A TRADITIONAL ORTHODONTIC PLAN**

PART D – PAYMENT METHOD

☐ ACH (Preferred Method) Please include an ACH Authorization Form and voided check.

☐ Wire Transfer

☐ Check

PART E - FUNDING TYPE

☐ RISK The first month's premium check must accompany this completed Master Dental Contract Application. Future premium payments are due on the first of each premium month.

RATES SOLD:

Employee (EE): $ _____ EE + 1: $ _____ EE + Spouse: $ _____ EE +Child(ren): $ _____ Family: $ _____

☐ ASO Weekly

ADMIN. FEE SOLD:

Percentage of Claims: _____ % Per Employee Per Month: $ _____ ☐ Other: _____

PART F - AGENT OF RECORD (if applicable)

Agency Name _____ Broker Name _____

Address _____ Phone ( ) _____

_____ Fax ( ) _____

City _____ State _____ Zip Code _____

_____
Tax ID Number

Note: Commissions will be paid to this TIN.

_____ _____
Broker Signature MN Insurance Producer License ID Number

PART G - INSTRUCTIONS

1. Complete Master Dental Contract Application.
2. Have each employee complete and sign a Membership Enrollment Form
3. Send this completed application, completed Membership Enrollment Forms, as well as the completed ACH Form, voided check and the initial remittance (if applicable) to the following address: **Delta Dental of Minnesota: ATTN: Sales, 3560 Delta Dental Drive, Eagan, MN 55122-3166**

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than twenty-five.

Delta Dental will send a contract upon acceptance of the application and final approval of the Dental Benefit Plan Summary. The contract will indicate the effective date of coverage. The contract is effective only after Delta Dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental.

SIGNATURE BOX

Signature of Authorized Company Official	Title	Date
Group Administrator/Future Correspondence Contact (please print)	Title	
( ) ( )		
Phone Number Fax Number	E-mail Address	