

Submission Requirement Checklist

To ensure efficient turnaround time, please use this checklist to confirm commonly missed information when submitting a new pooled group.

MASTER DENTAL CONTRACT APPLICATION

Part A: Company Information

- Plan Effective Date
- Coverage type. If “employee-only” is selected, dependent coverage will not be available to current or future employees.
- Eligibility waiting period for new employees (probationary period)

Does your company currently have a dental plan? If yes, please include the following:

- Current billing statement (**Only needed if company is electing Dental Flex**)
- Copy of current plan summary/benefit page to verify comparable coverage if replacing dental plan. (**Only needed if company is electing Dental Flex**)
- Number of months/years with current coverage if replacing dental plan.

Part B: Participation

- Indicate total number of eligible employees (defined as working 20 or more hours per week).
- Review Participation Guidelines for enrollment requirements for plan selected.
- Indicate participation requirement according to total amount of eligible employees

Part C or D (according to plan sold): Dental Program

- Indicate plan design selected
- Indicate deductible and maximum selected (if applicable)
- Enter rates sold in all applicable fields

Part E: Orthodontics (if applicable)

- Plan I- Traditional
- Plan II- Orthodontic Discount Program (Voluntary or Group)

Premium Remittance

- Indicate monthly billing or ACH (Automatic Check Handling)
- If monthly billing, include first months premium check made payable to Delta Dental
- If ACH, include ACH Authorization Form, first months premium check, and voided check

Enrollment Forms

- Verify all employee information (SSN, DOB, address, etc) is clear and legible.
- Part B-complete if electing Voluntary Orthodontic Discount Program
- Part D-complete only if company is electing Millennium Choice.
- Part F-must be complete if waiving coverage for employees and/or any eligible family members. Please include name of current dental carrier.
- If group is electing Dental Flex- Dental Flex enrollment forms must be completed (waivers do not need to fill out enrollment form)
- Employee and employer signature
- Part H – Complete all applicable fields, including group name

RETURN COMPLETED CHECKLIST TO:

Delta Dental ConnectSM

730 South Broadway

Gilbert, MN 55741

1-800-906-5250



Master Dental Contract Application Pooled Programs

PART A – COMPANY INFORMATION

Legal Company Name _____

Address _____ Phone (____) _____

City _____ State _____ Zip Code _____

Plan Effective Date: _____

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

Type of Coverage: Employee Only Employee and Dependents

Does your company currently have a dental plan? No Yes (name of carrier) _____

(Attach copy of most recent billing statement) Length of coverage: _____

PART B – PARTICIPATION

TOTAL NUMBER OF ELIGIBLE EMPLOYEES _____

Delta Dental Premier

- 5-14 Eligible Employees – 100% of all employees and 100% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. One time enrollment.
- 15-99 Eligible Employees – 100% of all employees and 75% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. Annual open enrollment for dependents only.
- 15-99 Eligible Employees – 80% of all employees and 80% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. One time enrollment.

Delta Dental PPO and Dual Option Program – Millennium Choice

- 5-9 Eligible Employees: 100% of all employees and 100% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. One time enrollment.
- 10-99 (Delta Dental PPO) and 10–199 (Dual Option Program): 80% of all eligible employees and 80% of dependents not covered elsewhere must enroll. A minimum of 5 employees must enroll. Annual open enrollment applies if 10 or more employees enroll.

Voluntary Program (Discover and Dental Flex)

- Your group must have five or more eligible employees. A minimum of five (5) employees must enroll. Discover – One time enrollment. Dental Flex – Annual open enrollment.
- MEDICAL LOCK** (Must include a copy of most recent medical billing statement)

PART C – DENTAL PROGRAM (choose one):

Delta Dental Premier	Delta Dental PPO	Rates Sold*																																
<input type="checkbox"/> Preventive Plan <input type="checkbox"/> Basic Plan <input type="checkbox"/> Comprehensive Standard Deductible: <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 Annual Maximum: <input type="checkbox"/> \$1,000 (5 – 99 enrolled employees) <input type="checkbox"/> \$1,500 (30 – 99 enrolled employees) <input type="checkbox"/> Comprehensive Enhanced Deductible: <input type="checkbox"/> \$25/\$75 <input type="checkbox"/> \$50/\$150 Annual Maximum: <input type="checkbox"/> \$1,000 (5 – 29 enrolled employees) <input type="checkbox"/> \$1,250 (30 – 99 enrolled employees)	<i>Select one Plan / Annual Maximum and one Deductible</i> <table border="0"> <tr> <td style="text-align: center;">Plan/Annual Max</td> <td style="text-align: center;">Deductible</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> I \$2,000</td> <td><input type="checkbox"/> \$25/\$75</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> II \$2,000</td> <td><input type="checkbox"/> \$50/\$150</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> III \$1,250</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> IV \$1,250</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="2"><input type="checkbox"/> PPO Plan with \$100 Lifetime Deductible and Escalating Maximum</td> <td></td> <td></td> <td></td> </tr> </table>	Plan/Annual Max	Deductible				<input type="checkbox"/> I \$2,000	<input type="checkbox"/> \$25/\$75				<input type="checkbox"/> II \$2,000	<input type="checkbox"/> \$50/\$150				<input type="checkbox"/> III \$1,250					<input type="checkbox"/> IV \$1,250					<input type="checkbox"/> PPO Plan with \$100 Lifetime Deductible and Escalating Maximum					Rates	Ortho Discount Program Rates <i>(If Electing)</i>	Total Rates <i>(With Elected Discount Program)</i>
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		Family	Family	Family																														
	Dual Option Program – Millennium Choice <table border="0"> <tr> <td style="text-align: center;">Plan <i>(Choose One)</i></td> <td style="text-align: center;">Deductible <i>(Choose One)</i></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Standard</td> <td><input type="checkbox"/> \$25/\$75</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Enhanced</td> <td><input type="checkbox"/> \$50/\$150</td> <td></td> <td></td> <td></td> </tr> </table>	Plan <i>(Choose One)</i>	Deductible <i>(Choose One)</i>				<input type="checkbox"/> Standard	<input type="checkbox"/> \$25/\$75				<input type="checkbox"/> Enhanced	<input type="checkbox"/> \$50/\$150				*3-Tier rating is the only option for Dual Option-Millennium Choice and Delta Dental PPO Plan with \$100 Lifetime Deductible and Escalating Maximum PLEASE NOTE: .25% premium discount for ACH.																	
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PART D – VOLUNTARY PROGRAM

<input type="checkbox"/> Discover I * - \$0 Deductible - \$500 Annual Maximum <input type="checkbox"/> Discover II * - \$25 Deductible - \$500 Annual Maximum <input type="checkbox"/> Discover III * - \$25 Deductible - \$750 Annual Maximum <p>* DISCOVER NOTE: Orthodontics included for groups with 10 or more enrolled employees and limited to dependent children age 8 – 18. Ortho not available if less than 10 enrolled.</p>	Employer Premium Contribution 50% or greater? <input type="checkbox"/> No <input type="checkbox"/> Yes <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th colspan="3">Rates Sold*</th> </tr> <tr> <th>Rates</th> <th>Ortho Discount Program Rates <i>(If Electing)</i></th> <th>Total Rates <i>(With Elected Discount Program)</i></th> </tr> </thead> <tbody> <tr> <td>Single</td> <td>Single</td> <td>Single</td> </tr> <tr> <td>Single+1</td> <td>Single+1</td> <td>Single+1</td> </tr> <tr> <td>Family</td> <td>Family</td> <td>Family</td> </tr> </tbody> </table>	Rates Sold*			Rates	Ortho Discount Program Rates <i>(If Electing)</i>	Total Rates <i>(With Elected Discount Program)</i>	Single	Single	Single	Single+1	Single+1	Single+1	Family	Family	Family
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Single+1	Single+1	Single+1														
Family	Family	Family														
<input type="checkbox"/> Dental Flex Plan - Dental Flex Enrollment Form Required <p>Waiting Periods:</p> <p>New Group With Prior Dental Coverage-Employees who enroll at the time the group converts to Delta Dental receive credit toward waiting periods based on the length of time the group had prior comparable coverage. All employees receive the same waiting period credit whether or not they were enrolled in the prior comparable plan.</p> <p>New Employee-The employee does not receive credit toward waiting periods for prior dental coverage from a former employer. Employees and covered dependents will need to complete all required waiting periods.</p>	<p>*3-Tier rating is the only option for Dental Flex; Discover 3-tier rating is available for groups with 100+ enrolled employees.</p> <p>PLEASE NOTE: .25% premium discount for ACH.</p>															

PART E - ORTHODONTICS

<input type="checkbox"/> PLAN I – TRADITIONAL ORTHODONTICS (For groups with 10 or more enrolled employees.) Does the prior dental plan have orthodontic coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes Please Note: If you are adding orthodontics and the previous dental plan did not have orthodontic coverage, there will be a 12-month waiting period for orthodontic benefits under the Dental Flex plan.	<input type="checkbox"/> PLAN II – ORTHODONTIC DISCOUNT PROGRAM <input type="checkbox"/> Group Plan – All Enrolled Employees Must Elect <input type="checkbox"/> Voluntary Plan – Individual Employee Election <i>(Include rates in Part C or D where applicable)</i>
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AGENT OF RECORD (if any) Completion of all fields required

Name _____	Agency _____
Address _____	Phone () _____ E-mail Address _____
City _____	State _____ Zip Code _____
Agent Signature / MN Insurance Agent License ID Number _____	Tax ID Number for Commissions Payment _____

PREMIUM REMITTANCE AND SUBMISSION

The first month's premium must accompany the application. Thereafter, the monthly premium payment and the corresponding statement or invoice must be received by the first of each month.

- Select Payment Option: ACH* CHECK WIRE
***Please note: .25% premium discount for ACH** (Include ACH Authorization Form and voided check)
- Complete application. Retain a copy for your files.
- Have each employee complete and sign a Membership Enrollment Form.
- Send the original Master Dental Contract Application, completed Membership Enrollment Forms and the first month of premium to: Delta Dental of Minnesota, 730 S. Broadway, Gilbert, MN 55741 **ATTN: Delta Dental ConnectSM**. For questions call (651) 406-5920 or 1-800-906-5250.

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 five.

Delta Dental will return a contract upon acceptance of the application. 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 () _____	Email Address _____