DELTA DENTAL

North Dakota

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) _____

(Include a 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.

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** (A copy of most recent medical billing statement is required)

PART C – TRADITIONAL DENTAL PROGRAM (choose one):

Delta Dental Premier	Rates Sold	
☐ Comprehensive Standard Deductible: ☐ $25/$75 ☐ $50/$150 Annual Maximum: ☐ $1,000 ☐ $1,500	**Rates**	
	Single	
	Single +1	
	Family	
☐ Comprehensive Enhanced Deductible: ☐ $25/$75 ☐ $50/$150 Annual Maximum: ☐ $1,000 ☐ $1,250	PLEASE NOTE: .25% premium discount for ACH	

PART D - VOLUNTARY PROGRAM (choose one):

☐ **Dental Flex Plan** – Dental Flex Enrollment Form Required

Waiting Periods:

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.

New Employees-New Employees do not receive credit toward waiting periods for prior dental coverage from a former employer. New employees and covered dependents must complete all required waiting periods.

Employer Premium Contribution 50% or greater? ☐ No ☐ Yes

Rates Sold

Single	
Single + 1	
Family	

PLEASE NOTE: 25% premium discount for ACH for plans with Traditional Dependent Child Coverage (to age 26)

☐ **Discover Plan**

***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. Discover is not eligible for Essential Pediatric Dental Benefits

PART E - PEDIATRIC DENTAL BENEFITS (choose one):

☐ Traditional Dependent Child Coverage (to age 26)

The following certified Essential Pediatric Dental plans are available:

☐ Essential Pediatric Dental Group Plan A (to age 19)

☐ Essential Pediatric Dental Group Plan B (to age 19)

PART F - ORTHODONTICS

☐ **PLAN I – TRADITIONAL ORTHODONTICS**

(For groups with 10 or more enrolled employees.)

Does the prior dental plan have orthodontic coverage? ☐ No ☐ 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.

AGENT OF RECORD 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.

1. Select Payment Option: ☐ ACH* ☐ CHECK ☐ WIRE
***Please note: .25% premium discount for ACH** (Include ACH Authorization Form and voided check)

2. Complete Master Dental Contract Application. Retain a copy for your files.
3. Have each employee complete and sign a Membership Enrollment form or be identified on an approved Enrollment spreadsheet completed by the Group Administrator.
4. Send the Master Dental Contract Application, completed Membership Enrollment forms or approved Enrollment spreadsheet, corresponding Dental Proposal and the first month of premium to: Delta Dental of Minnesota, 730 S. Broadway, Gilbert, MN 55741 **ATTN: Delta Dental Connect℠**. For questions call (651) 406-5920 or 1-800-906-5250 or contact deltadentalconnect@deltadentalmn.org.

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