DELTA DENTAL

Delta Dental of Minnesota

Master Contract Application For Certified Health Care Reform Group Dental Plans

PART A - COMPANY INFORMATION

Legal Company Name ______________________________

Address ______________________________ Phone ( ) ______________________________

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City ______________________________ State ____________ Zip Code ____________

Plan Effective Date: ______________________________

Total Number of Eligible Employees: ______________

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

Type of Coverage: ☐ Employee Only ☐ Employee and Dependents ☐ Child Only (to age 19)

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

Does your company currently have a medical plan? ☐ No ☐ Yes (name of carrier) ______________________________

PART B – DENTAL PLANS

CHECK ONE PLAN THAT WILL BE OFFERED:

Plan	Per Member Per Month Rate Sold
☐ Delta Dental Pediatric Low	
☐ Delta Dental Pediatric High	

CHECK ONE IF APPLICABLE:

Plan	Per Member Per Month Rate Sold
☐ Delta Dental Bronze	
☐ Delta Dental Silver	
☐ Delta Dental Gold	
☐ Delta Dental Platinum	

AGENT OF RECORD (if any) **Completion of all fields required**

Name Address	______________________	Agency	______________________	
City	______________________	Phone	( ) ______________________	
E-mail Address	______________________	State	__________	Zip Code __________
	______________________		______________________	
	______________________		Tax ID Number	
	Agent Signature / Insurance Agent License ID #		**Note: Commissions will be paid to this TIN.**	

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 - Include ACH Authorization Form and voided check
   ☐ CHECK ☐ WIRE ☐ Other ______________________

2. Complete application. Retain a copy for your files.
3. Have each eligible employee complete and sign a Membership Enrollment Form.
4. Send the original application, completed Membership Enrollment Forms, 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 email deltadentalconnect@deltadentalmnadmin.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 Company (Company as named in Part A above) and agree to provide substantiating evidence when requested.

If Delta Dental accepts this application, Delta Dental will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

SIGNATURE BOX

Signature of Authorized Company Official ______ Title ______ Date ______

Group Administrator/Future Correspondence Contact (please print) ______ Title ______

( ) Phone Number ______ ( ) Fax Number ______ Email Address ______