Delta Dental of Minnesota

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 dependents. Eligibility waiting periods for new employees (probationary period)

Does your company currently have a dental plan? If yes, please indicate 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

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 requirements according to total amount of eligible employees

Part B: Dental Program (according to plan sold)

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

Part C : Orthodontics (if applicable)

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

Premium Remittance

☐ Indicate monthly billing or ACH (Automatic Clearing House)
☐ If monthly billing, include first months premium check made payable to Delta Dental
☐ If ACH, include ACH Authorization form, first month's premium check, and voided check

Enrollment Forms

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

Return Completed Checklist To:

Delta Dental Connect℠
730 South Broadway
Gilbert, MN 55741
1-800-906-5250

Delta Dental of Minnesota

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 and benefit summary) Prior Plan Start Date: _____

Total Number of Eligible Employees: _____

Part B - Delta Dental PPO Plus Premier Dental Program Options (choose only one and complete the options in the section):

☐ **Delta Dental PPO Plus Premier™ - Dental Access:** Available for groups with 5-199 eligible employees, minimum of 5 employees must enroll - Annual Open Enrollment

Deductible Options - select one
- ☐ Annual - $50 per person/ $150 per family
- ☐ Lifetime - $100 per person/ $300 per family

Annual Plan Maximum Options - select one
- ☐ $1,000 per person per year
- ☐ $1,500 per person per year
- ☐ $2,000 per person per year

Basic Service Coverage Level - select one
- ☐ 80%
- ☐ 50%

Orthodontic Coverage - minimum of 5 enrolled employees. Coverage for members ages 8-99, coverage at 50%, Lifetime Ortho Max matches Annual Plan Maximum selection, 6 month waiting period applies for new groups without 12 months of prior comprehensive coverage.

- ☐ Yes, we accept orthodontic coverage
- ☐ No, we decline orthodontic coverage

☐ **Delta Dental PPO Plus Premier™ - Dual Option Millennium Choice:** 5-199 Eligible Employees: 80% of all eligible employees and 80% of dependents not covered elsewhere must enroll. A minimum of 5 employees must enroll. Annual Open Enrollment

Plan - Select one
- ☐ Standard
- ☐ Enhanced

Orthodontic Coverage - minimum of 10 enrolled employees. Coverage for dependent children ages 8-18, coverage at 50%, Lifetime Ortho Plan Maximum $1,000
- ☐ Yes, we accept orthodontic coverage
- ☐ No, we decline orthodontic coverage

☐ **Delta Dental PPO Plus Premier™ - Dental Flex:** Available for groups with 5-999 eligible employees, minimum of 5 employees must enroll. Annual Open Enrollment

Annual Plan Maximum Options - select one:
- ☐ $1,000 per person per year
- ☐ $1,500 per person per year

Orthodontic Coverage - minimum of 10 enrolled employees. Coverage for dependent children ages 8-18, coverage at 50%, lifetime Ortho Plan Maximum $1,000, 12 month waiting period applies for new employees and groups without 12 months of prior orthodontic coverage.
- ☐ Yes, we accept orthodontic coverage
- ☐ No, we decline orthodontic coverage

Part C - Orthodontics

Please note: If traditional orthodontics was not elected on page 1, then the Orthodontic Discount Program is an option for Dental Access, Millennium Choice, and Dental Flex products only.

Orthodontic Discount Program

☐ Group Plan - For all Enrolled Employees Must Elect
☐ Voluntary Plan - Individual Employee Election
(Include rates in below where applicable)

	Rates Sold	
Rates	**Ortho Discount Program Rates** *(If Electing)*	**Total Rates** *(With Elected Discount Program)*
Employee	Employee	Employee
Employee+1	Employee+1	Employee+1
Family	Family	Family

Agent of Record Completion of all fields required

Name: _____ Agency: _____

Address: _____ City: _____ Zip Code: _____

Phone: (_____)_____ Email Address: _____

_____ _____

Agent Signature/ 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

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@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. 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.

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