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 (_____) _____

_____

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:

	Per Member Per Month Rate Sold
☐ Delta Dental Kids Plan	

CHECK ONE IF APPLICABLE:

☐ 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 yourfiles.
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 fraudulent 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