DELTA DENTAL

SERVING NORTH DAKOTA

Master Dental Contract Application Pooled Programs

PART A - COMPANY INFORMATION

Legal Company Name ______________________

Address ______________________ Phone ( ) ______________________

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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 Access** - available for groups with 5 - 99 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 previous comprehensive coverage

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

Rates:
- ☐ Employee
- ☐ Employee + 1
- ☐ Family

☐ **Delta 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 previous orthodontic coverage

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

Rates:
- ☐ Employee
- ☐ Employee + 1
- ☐ Family

Delta Dental Certified Healthcare Reform Plans - available for groups with 1 - 999 eligible employees - Annual Open Enrollment

Pediatric Dental Plan - for members under age 19

- ☐ Delta Dental Individual and Family℠ Kids Plan

Adult Dental Plan - for members age 19 and older - May select one

- ☐ Delta Dental Individual and Family℠ – Bronze
- ☐ Delta Dental Individual and Family℠ – Silver
- ☐ Delta Dental Individual and Family℠ – Gold
- ☐ Delta Dental Individual and Family℠ – Platinum

Rates:

Per member per month - Pediatric ☐

Per member per month - Adult ☐

AGENT OF RECORD Completion of all fields required

Name		Agency			
Address		Phone	( )	E-mail Address	
City		State		Zip Code	
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**SM. 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