Delta Dental of Minnesota

Master Application
Delta Dental Small Group Clients

PART A – Company Information

Legal Company Name _____

Address _____ Phone (____)_____

_____

City _____ State _____ Zip Code _____

Plan Effective Date: _____

Eligibility probationary period for new employees: First of the month following _____ Other _____

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 _____

Client Contact Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ Last Name _____

Title _____

Contact Type: ☐General ☐ Billing ☐ Renewal ☐ Mailing ☐ Materials

Telephone: _____ Ext: _____ Cell: _____

Fax: _____ Email Address:_____

☐ Same as Client Physical Location

Mailing Address: _____

City _____ State _____ Postal Code _____

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ Last Name _____

Title _____

Contact Type: ☐General ☐ Billing ☐ Renewal ☐ Mailing ☐ Materials

Telephone: _____ Ext: _____ Cell: _____

Fax: _____ Email Address:_____

☐ Same as Client Physical Location

Mailing Address: _____

City _____ State _____ Postal Code _____

Client – Employer Services Portal Registration

With the Employer Services Portal, you can enroll a new member, update existing members, view eligibility and dental benefits. In addition, **your monthly invoice and other billing details are provided to you *exclusively* through the Employer Services Portal.**

Select a Client Administrator within your company and complete the information below. This Client Administrator will create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will e-mail the Client Administrator with registration information and additional instructions.

Client Administrator Name: _____ Title: _____

Email: _____ Phone Number: _____

Note: The Client Administrator must be an employee of the client

PART B – Delta Dental PPO Plus Premier™ Dental Program Options (choose only one)

☐ **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

Please check (✓) one below:

- ☐ Annual - $50 per person/$150 per family
- ☐ Lifetime - $100 per person/$300 per family

Annual Plan Maximum Options

Please check (✓) one below:

- ☐ $1,000 per person per year
- ☐ $1,500 per person per year
- ☐ $2,000 per person per year

Basic Service Coverage

Please check (✓) one below:

- ☐ 80%
- ☐ 50%

Orthodontic Coverage - minimum of 5 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 – ***Please check (✓) one below:***

- ☐ Standard
- ☐ Enhanced

Orthodontic Coverage - minimum of 5 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

Please check (✓) one below:

- ☐ $1,000 per person per year
- ☐ $1,500 per person per year

Orthodontic Coverage - minimum of 5 enrolled employees. Coverage for dependent children ages 8-18, coverage at 50%, Lifetime Ortho Plan Maximum $1,000, Lifetime Ortho Max matches Annual Plan Maximum selection, 12 month waiting period applies for new employees and groups without 12 months of prior comprehensive coverage.

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

PART C – Broker of Record - Completion of all fields is required

Broker Name _____ Agency _____

Address _____

_____

City _____ State _____ Zip Code _____

Phone _____ E-mail Address _____

_____ _____

Broker Signature / Insurance Broker License ID Number Tax ID Number

Note: Commissions will be paid to this TIN

BROKER SERVICES PORTAL

With the Broker Services Portal, the Broker of Record can update and view the client's eligibility and access the client's billing details. The Broker/Agency will work with their Agency's Broker Administrator, who will add the appropriate user permissions to the Broker's access.

PART D – Premium Remittance and Submission

The first month's premium payment must be received in order for Delta Dental to pay claims for your members. Please submit your first month's premium with your application.

1. Select Payment Option: ☐ **ACH** ☐ **Check**
2. Complete the Plan Master Dental Contract Application.
3. Each eligible employee must complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator.
4. Send the Dental Contract Application, completed Enrollment Forms or approved Enrollment spreadsheet, corresponding Dental Proposal, and the first month of premium to:

Delta Dental of Minnesota
ATTN: Delta Dental Connect℠
500 Washington Ave South, Suite 2060
Minneapolis, MN 55415-1163

For questions call 1-800-906-5250 or DeltaDentalConnect@DeltaDentalMN.org

Client Administrator:
By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the 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

_____ _____

Client Administrator/Future Correspondence Contact (please print) Title

_____ _____ _____

Phone Number Fax Number Email Address