DELTA DENTAL

Delta Dental of Minnesota

Master Application
Delta Dental Small Business Clients

PART A – Client Information

Legal Company Name: _____

Physical Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip Code: _____

Mailing Address ☐ Same as client physical location: _____

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: _____

[Estimated enrolled Subscriber count:] _____ [SIC/NAICS Code:] _____

Client Contact Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ [General] ☐ [Renewal] ☐ [Billing] ☐ [Mailing] ☐ [Materials] ☐ [Overage Dependent]

Telephone: _____ Ext: _____ Cell: _____

Email Address: _____

☐ Same as Client Physical Location

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please choose ONE renewal delivery method:

- ☐ Please **email** renewal documents to the following email address (if different from above): _____
- ☐ Please **mail** renewal documents (provide address if different from Mailing Address): _____

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ [General] ☐ [Renewal] ☐ [Billing] ☐ [Mailing] ☐ [Materials] ☐ [Overage Dependent]

Telephone: _____ Ext: _____ Cell: _____

Email Address: _____

☐ Same as Client Physical Location

Mailing Address _____

City: _____ State: _____ Zip 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 Super User within your company and complete the information below. This Client Super User will create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will e-mail the Client Super User with registration information and additional instructions.

Client Super User Name: _____ Title: _____

Email: _____ Phone Number: _____

Note: The Client Super User 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™ - Delta Dental Solutions Dual Option:** Available for groups with 2 - 100 eligible employees, minimum of 2 employees must enroll. [Annual Open Enrollment]

Orthodontic Coverage - minimum of 2 enrolled employees. Coverage for age 8 up to age 19, Coverage at 50%, Lifetime Orthodontic Plan Maximum $1,000.

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

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Solutions 1000, 1500, and 2000:** Available for groups with 2 -100 eligible employees, minimum of 2 employees must enroll. [Annual Open Enrollment]

Deductible

Annual - $50 per person/$150 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 / with Orthodontic Coverage*

***Orthodontic Coverage** - minimum of 2 enrolled employees. Coverage for age 8 up to age 19, Coverage at 50%, Lifetime Orthodontic Maximum $2,000, 12 month waiting period. 12 month waiting period applies for new employees and groups without 12 months of prior comprehensive coverage.

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Flex:** Available for groups with [2-999] [or more] eligible employees, minimum of 2 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 2 enrolled employees. Coverage for age 8 up to age 19, Coverage at 50%, Lifetime Orthodontic Plan Maximum $1,000, Lifetime Ortho Max 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

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

Delta Dental PPO Plus Premier™ – Pathfinder Plans

Pathfinder Plans 1-6 [deductibles are per person/per family]

☐ **Pathfinder Plan 1** - $50/$150 annual deductible, $50 Lifetime deductible for Diagnostic & Preventive Services, $1000 annual maximum.

☐ **Pathfinder Plan 2** - $100/$300 deductible, $1500 annual maximum.

☐ **Pathfinder Plan 3** - $50/$150 annual deductible, $50 Lifetime deductible for Diagnostic & Preventive Services, $1500 annual maximum, **plan waiting periods do not apply.**

☐ **Pathfinder Plan 4** - $50/$150 annual deductible, $50 Lifetime deductible for Diagnostic & Preventive Services, $1500 annual maximum, **Orthodontic Coverage** - minimum of 2 enrolled employees Coverage for age 8 up to age 19, Coverage at 50%, **Lifetime Orthodontic Plan Maximum $1,000,** 12 month waiting period applies for new groups without 12 months of previous comprehensive coverage.

☐ **Pathfinder Plan 5** - $100/$300 deductible, $1500 annual maximum, 24 month initial contract.

☐ **Pathfinder Plan 6** - $100/$300 deductible, $1500 annual maximum, **plan waiting periods do not apply.**

Pathfinder Plans 1-6

2 - 100 Eligible Employees

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

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

Broker Name: _____ **Agency:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **E-mail Address:** _____

Please choose ONE renewal delivery method:

☐ Please **email** renewal documents to the following email address (if different from above): _____

☐ Please **mail** renewal documents (provide address if different from Mailing 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. TheBroker/Agency will work with their Agency's Broker Super User, 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** **Make payable to: Delta Dental of Minnesota and mail payments to**: Delta Dental of Minnesota, NW 5772, PO Box 1450, Minneapolis, MN 55485-5772
2. Complete the Master Dental Contract Application. Retain a copy for your files.
3. Have each employee complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator
4. Send the Master Dental Contract Application, completed Enrollment Forms or approved Enrollment spreadsheet, and corresponding Dental Proposal to:

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

5. **Completed applications and related materials may also be emailed to: Deltadentalconnect@deltadentalmn.org**

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 two.

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	Email Address	