DELTA DENTAL®

Group Application for Dental Benefits

(FOR 2 OR MORE EMPLOYEES)

Groups must be approved by Underwriting before coverage begins. Please complete entire application for prompt approval.

APPLICANT INFORMATION

Full Legal Name of proposed Applicant (as it will appear on policy):				
Street Address:			P.O. Box:	Phone:
City:	State:	Zip:	Industry Type:	Fax:
Owner/President:	Title:		Email Address:	Phone:
Plan Administrator:	Title:		Email Address:	Phone:
Eligibility Contact:	Title:		Email Address:	Phone:

REQUESTED EFFECTIVE DATE

We request for this plan to become effective on the first day of _____ , 20_____ , provided that all of the following has been completed within 15 days of the effective date:

1. The Application has been received and the underwriting documentation has been received and approved by Delta Dental of Idaho, and
2. Delta Dental of Idaho has been furnished with the completed/signed enrollment cards for all employees, and
3. First month's premium check and all future checks must be submitted to: Delta Dental of Idaho Bank Lockbox Processing, PO Box 271372, Salt Lake City, UT 84127-1372.
   Future payments are to be made by the tenth (10th) of each consecutive month.

Total number of **ALL** employees: _____ Total number of **ALL** eligible employees: _____ Total number of employees enrolled: _____

Medical Carrier:	Renewal Month:	Medical Plan Number:

PLAN DETAIL

Plan Selected:

- ☐ PPO 50 – $1,000
- ☐ PPO 50 – $1,250/$1,000
- ☐ PPO 50 – $1,250/$1,000 + Rollover
- ☐ PPO 50 – $1,500/$1,000
- ☐ PPO 50 – $1,750/$1,000
- ☐ PPO 25 – $1,000
- ☐ PPO 25 – $1,250/$1,000
- ☐ PPO 25 – $1,250/$1,000 + Rollover
- ☐ PPO 25 – $1,500/$1,000
- ☐ PPO 25 – $1,750/$1,000
- ☐ PPO Triple SELECT
- ☐ PPO Basic
- ☐ PPO Preventive
- ☐ PPO High/Low One Preventive | PPO 50 $1,000
- ☐ PPOHigh/Low Two Preventive | PPO 50 $1,200/$1000
- ☐ Premier 50 – $1,000
- ☐ Premier 50 – $1,000 + Rollover
- ☐ Premier 50 – $1,250
- ☐ Premier 50 – $1,500
- ☐ Premier 50 – $1,750

These plans are also available to groups with 10 or more enrolled employees:

- ☐ PPO 50 – $1,250 child orthodontia, $1000 lifetime maximum
- ☐ PPO 25 – $1,250 child orthodontia, $1000 lifetime maximum
- ☐ Premier 50 – $1,000 child orthodontia, $1000 lifetime maximum

Funding Type:

- ☐ Community Pool
- ☐ School Pool
- ☐ Experience Rated
- ☐ Administrative Service Contract *

* If Administrative Service Contract program:
$ _____ per employee per month, or _____ %
of claims paid will be the cost for administration.

Funding of ASC group claims paid will be:

- ☐ Weekly ACH payment via website
- ☐ Prefund $ _____

Previous Dental:	☐ Yes	☐ No	If YES, List CARRIER, ADDRESS & EFFECTIVE DATES:
Honor Deductibles:	☐ Yes	☐ No	If YES, list DEDUCTIBLE AMOUNT: $
Current Orthodontics (takeover):	☐ Yes	☐ No	

CURRENT YEAR-TO-DATE DEDUCTIBLE AND/OR MAXIMUM TAKEOVER LIST REQUIRED WITHIN 30 DAYS OF ACTIVATION DATE FOR EXPERIENCE-RATED AND ASC GROUPS.

PLAN RATE CALCULATION

Rate Calculation:	Number of Employees	Multiply	Rate	Monthly Premium (Rate x Employees)
Employee Only		X	$	$
Employee + Spouse		X	$	$
Employee + 1 Child		X	$	$
Employee + 2 or more Children		X	$	$
Employee + Spouse + 1 or more Children		X	$	$
TOTAL NUMBER OF EMPLOYEES		TOTAL MONTHLY PREMIUM		$

Payments and Billing

Payments will be made via:

- ☐ ACH (on Delta Dental of Idaho's website)
- ☐ Paper check

Billing is available electronically.

- ☐ Check if you would prefer paper billing

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Group Application for Dental Benefits

(FOR 2 OR MORE EMPLOYEES, CONTINUED...)

UNDERWRITING REQUIREMENTS

General guidelines for all employers with 2 to 99 eligible employees

1. Voluntary plans do not require any employer contribution toward employee dental premiums.
2. Groups must maintain a minimum of two (2) enrolled employees.
3. Minimum enrollment of 35% of eligible employees is required for voluntary groups.
4. A group must consist of 75% or more of Idaho residents or a surcharge may apply.
5. Companies must be in business at least twelve (12) months.
6. The previous deductible will be honored providing the covered employee has proof of deductible taken during the calendar year, and prior to enrollment with Delta Dental.
7. Orthodontia coverage requires ten (10) or more enrolled employees.
8. Coverage will terminate for an eligible employee on the last day of the month in which employment terminates.
9. Industry Restrictions: Due to high turnover trends and/or lack of employee/employer relationship, some industries, such as restaurants, gas stations, insurance (commissioned agents), hotel, motel, retail, beauty/barber shops and real estate (commissioned agents), are restricted and may deviate from the eligibility and underwriting requirements.
10. Late Enrollee Provision: Any employee and/or their dependent(s) who do not enroll in the dental plan following completion of the employee's eligibility period, as defined above, will have a 12-month waiting period for Major Services and, if applicable, Orthodontic Services.

ELIGIBILITY OPTIONS

1. Married employees will enroll: ☐ Separately ☐ Under one rate category
2. Eligible employees work _____ hours per week.
3. Employees become eligible for benefits the first of the month following (check one): ☐ 3 months ☐ 2 months ☐ 1 month ☐ Other _____
4. The employer contributes _____ % toward the employee dental premium.
5. The employer contributes _____ % toward the dependent dental premium.
6. Employees who have not reached the end of their probation period are eligible: ☐ At group initial enrollment ☐ After completion of probationary period

PRODUCER OF RECORD (The Producer/Agent indicated below is hereby designated as our Producer/Agent of Record for dental coverage.)

Producer/Agent Name:		Agency Name:	
Phone:	Fax:	Email:	
Address:	City:	State:	Zip:
Make Commission Checks Payable To: ☐ Producer ☐ Agency Producers and Agencies MUST be licensed with the Idaho Department of Insurance and appointed with Delta Dental of Idaho.		Producer or Agency Taxpayer I.D.#: Idaho License #:	

AGREEMENT (This agreement will be in force per the terms of the Contract)

Applicant Name (please print):	
Name of Decision Maker (please print):	Title:
Decision Maker's Signature:	Date Application Signed:

DELTA DENTAL USE ONLY			Check Amount:	Date Approved:
NAICS	County	LMA	Lock Box Receipt Number:	Group Number:
Territory: ☐ One ☐ Two ☐ Three			Date Received:	Effective Date:
Vendor Number:	Commission:		Received By:	

Groups Must Be Approved By Underwriting Before Coverage Begins. This Is Not A Contract.

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