



GROUP APPLICATION FOR SMALL BUSINESSES



A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Group Information				
Group name				
4 digit SIC Code	Industry Type		<input type="checkbox"/> Level 1	<input type="checkbox"/> Level 2
Contact person	Telephone number	E-mail		Fax Number
Street address	City	State	ZIP code	
Billing address (if different)	City	State	ZIP code	
Will your group offer dual choice to its employees (choice of two Delta Dental programs?) <input type="checkbox"/> Yes. Delta Dental is carrier for both programs. <input type="checkbox"/> No			Will this Delta Dental program replace existing dental coverage your group currently has through another dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, name of previous carrier:	
Proposed effective Date of coverage	Signature of company officer			Date
Name (print)		Title (print)		

Classic Program (5-49 eligible employees)

Select one plan and benefits that apply:				
Plans	<input type="checkbox"/> PPO A	<input type="checkbox"/> PPO B-12	<input type="checkbox"/> PPO C	<input type="checkbox"/> PPO Vol
D&P maximum waiver	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Calendar year maximum	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000
Orthodontic Coverage* (child only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Options Program (50-99 eligible employees)

Select one plan and benefits that apply:				
Plans	<input type="checkbox"/> PPO 1	<input type="checkbox"/> PPO 2	<input type="checkbox"/> PPO 3	
D&P maximum waiver	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deductible	<input type="checkbox"/> \$25/75 <input type="checkbox"/> \$50/150	<input type="checkbox"/> \$25/75 <input type="checkbox"/> \$50/150	<input type="checkbox"/> \$40/120 (in) and \$50/150 (out) <input type="checkbox"/> \$0 (in) and \$25/75 (out)	
Endodontics/periodontics	<input type="checkbox"/> Basic <input type="checkbox"/> Major	<input type="checkbox"/> Basic <input type="checkbox"/> Major	<input type="checkbox"/> Basic <input type="checkbox"/> Major	
Calendar year maximum	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	
Orthodontic coverage*	<input type="checkbox"/> No <input type="checkbox"/> Child <input type="checkbox"/> Adult and child	<input type="checkbox"/> No <input type="checkbox"/> Child <input type="checkbox"/> Adult and child	<input type="checkbox"/> No <input type="checkbox"/> Child <input type="checkbox"/> Adult and child	
Lifetime orthodontic maximum	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	

Vision By EyeMed **	Census Data - Delta Dental PPO SM	
<input type="checkbox"/> No Vision <input type="checkbox"/> Standard <input type="checkbox"/> Enhanced	Employer Contribution Employee _____% Minimum 75%*** Dependents _____% Employer contributions will be made using pretax dollars <input type="checkbox"/> Yes <input type="checkbox"/> No	Total number of eligible employees: _____ Total number of enrollees: _____

Dental Distribution by Dependency Status/Dues					Dental Distribution by Dependency Status/Dues				
3 Tier	Dental Rates	Vision Rates	# of Enrollees	Total	4 Tier	Dental Rates	Vision Rates	# of Enrollees	Total
One party	_____ + _____	x _____	= _____		EE	_____ + _____	x _____	= _____	
Two party	_____ + _____	x _____	= _____		EE + S	_____ + _____	x _____	= _____	
Three party+	_____ + _____	x _____	= _____		EE + C	_____ + _____	x _____	= _____	
Total			= _____		EE + F	_____ + _____	x _____	= _____	
					Total				= _____

* PPO A, B-12 and C require minimum of 10 primary enrollees. Voluntary PPO requires minimum of 25 primary enrollees

** Underwritten by Fidelity Security Life Insurance Company, 3130 Broadway, Kansas City, MO 64111 • Vision Policy Form # M9004

*** 75% to 99.9% contribution requires at least 80% eligible employee participation. 100% contribution requires 100% eligible employee and eligible dependent participation.

Census Data - DeltaCare® USA program		
Program Design (check one)	Employer Contribution (check one)	
<input type="checkbox"/> 10A	<input type="checkbox"/> Option A, Non-voluntary (at least 75% employer paid)	Total number of eligible employees: _____
<input type="checkbox"/> 11A	<input type="checkbox"/> Option B, Voluntary dependents	Total number of enrollees: _____
<input type="checkbox"/> 12A	<input type="checkbox"/> Option C, Voluntary (100% employee paid)	
<input type="checkbox"/> 15B		

Dental Distribution by Dependency Status/Dues					Dental Distribution by Dependency Status/Dues				
3 Tier	Dental Rates	Vision Rates	# of Enrollees	Total	4 Tier	Dental Rates	Vision Rates	# of Enrollees	Total
One party	_____	+	_____ x _____	= _____	EE	_____	+	_____ x _____	= _____
Two party	_____	+	_____ x _____	= _____	EE + S	_____	+	_____ x _____	= _____
Three party+	_____	+	_____ x _____	= _____	EE + C	_____	+	_____ x _____	= _____
Total				= _____	EE + F	_____	+	_____ x _____	= _____
					Total				= _____

Employee Eligibility Period (check one):	Domestic Partner Coverage
<input type="checkbox"/> Standard: First of month, following 90 days of employment	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Custom: As mirrors group medical plan:	If yes, check one of the following:
<input type="checkbox"/> 1. First of the month following date of hire	<input type="checkbox"/> Domestic partner only
<input type="checkbox"/> 2. Date of hire (group must pay dues to entire month of coverage regardless of date of hire)	<input type="checkbox"/> Domestic partner and children of domestic partner
<input type="checkbox"/> 3. First of the month following _____ days of employment (minimum of 30 days)	

Submit to Your Broker	
Delta Dental PPO and EyeMed Vision	DeltaCare USA
1) this completed application	1) this completed application
2) completed Enrollment/Change forms for each eligible employee	2) completed Enrollment forms for each enrollee
3) Most recent FICA or SDI Tax Filing (DE 9C)	3) HIPAA Business Associate Addendum
4) HIPAA Business Associate Addendum	4) a check for your first month's dues (dental and vision) made payable to Delta Dental
5) Check for your first month's dues (dental and vision) made payable to Delta Dental	

IT IS AGREED THAT DUES AND A CURRENT ELIGIBILITY LIST WILL BE SUBMITTED TO DELTA DENTAL'S DESIGNATED ADMINISTRATOR BY THE 25th OF THE MONTH PRIOR TO THE COVERAGE MONTH.

The program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. It is understood and agreed that this application be made a part of such agreement.

Broker Information			
Broker's name	Telephone number	Fax number	
Company name			
Mailing address	City	State	ZIP Code
Broker's signature	Broker's E-mail	Date	
Please furnish one: <input type="checkbox"/> Social Security number		<input type="checkbox"/> TIN number	Company is Inc. <input type="checkbox"/> Yes <input type="checkbox"/> No

General Agent Information
GA Company
GA Sales Representative
Delta Dental Account Executive