



For Delta Dental of Oklahoma Use Only:
Group No. _____

APPLICATION FOR GROUP CONTRACT
Delta Dental of Oklahoma – Federally Compliant Plans (FCPs)
For Plan Year 2019

This Application for Group Contract is hereby made a part of the Plan Agreement and is subject to all terms and conditions of said Agreement. This Application for Group Contract will not be accepted unless **signed and completed in its entirety**.

Step 1 – EMPLOYER INFORMATION

Legal Business Name (as it should appear on Summary Plan Description and Plan Agreement)

DBA (if applicable)

Physical Address

City State Zip

Billing/Mailing Address (if different from the physical address)

City State Zip

Telephone Number Fax Number

Website Address

Type of Business

Federal Tax ID Number SIC Code

ERISA Exempt: No Yes (exemption typically only applies to government employers/entities or religious institutions)

Group Executive Title

Email Telephone Fax

Group Contact Title

Email Telephone Fax

Billing Contact Title

Email Telephone Fax

Eligibility Contact Title

Email Telephone Fax



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Step 2 – PLAN EFFECTIVE DATE: (Month): _____ (Day): _____, 2019

Step 3 – ELIGIBILITY AND ENROLLMENT: A minimum of two (2) enrolled individuals per plan required for participation in FCP plans.

Total Number Employees: _____ Total Number Ineligible Employees*: _____
Total Number Eligible Employees: _____
*Indicate Reason(s) for Ineligibility _____

Employees are eligible for coverage on (select one):

- The date of hire
 The first of the month following the date of hire
 The _____ day of continuous, full-time employment*
 The first of the month following _____ days of continuous, full-time employment*

*Cannot exceed 90 days between first day of full-time employment and coverage start date.

Step 4 – FULLY INSURED PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Plan Year: Calendar

MONTHLY RATES FOR COMBINED PLANS	<input type="checkbox"/> Low Option	<input type="checkbox"/> High Option
Ages 0 – 20 (Per Covered Person)	\$20.00	\$40.00
Ages 21 and older (Per Covered Person)	\$20.00	\$40.00

MONTHLY RATES FOR PEDIATRIC PLANS (must be under age 19)	<input type="checkbox"/> Low Option	<input type="checkbox"/> High Option
One Covered Person	\$20.00	\$40.00
Two Covered Persons	\$40.00	\$80.00
Three or more Covered Persons	\$60.00	\$120.00

BENEFITS SUMMARY

		Low Options	High Options
Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%	100%
	Class II – Basic Services	60%	80%
	Class III – Major Services	50%	50%
	Class IV – Orthodontic Services*	50%	50%
Deductible per Plan Year – Combined Low and Pediatric Low	Class I, II and III Services Only	\$75 per Person	n/a
Deductible per Plan Year – Combined High and Pediatric High	Class II and II Services Only	n/a	\$50 per Person
Plan Maximum Year Benefit Payment – for covered persons age 19 and older only	Class I, II and III Services Combined	\$1,500	\$1,500
	Plan Benefit Limitation Period(s) – for covered persons age 19 and older only	Class II Services	6 Months
Maximum Out of Pocket Cost Per Benefit Plan Year – for covered persons to age 19	Class III Services	12 Months	12 Months
	One Covered Person	\$350	\$350
	Two or more Covered Persons	\$700	\$700

*Medically Necessary Only for Covered Person(s) to age 19

Step 5 – EMPLOYER CONTRIBUTION

Employer Contributes _____% OR \$ _____ to **employee** cost of plan.

Employer Contributes _____% OR \$ _____ to **dependent** cost of plan.



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Step 6 – OPTIONS FOR ACCESS TO ONLINE RESOURCES

Enter the information for each contact that is to receive online access through Online Resources. If a contact should have access to all subgroups then enter "ALL" in the Subgroup(s) Access box. Select each type of access. You may choose one method of invoice receipt, E-Bill or Bill by Fax.

An email address is required for each contact requesting access to Online Resources.

Subgroup Access: Name the contact(s) who will receive access to the specified subgroup(s).

Online Eligibility: Name the contact(s) who will receive access to *view and/or modify* eligibility in Online Resources.

View Only: Read-only access to online eligibility.

Modify: Ability to make changes through online eligibility.

Billing: Name the contact(s) who will receive access to billing.

E-Bill: Access to receive the invoice through email.

Bill by Fax: Access to receive the invoice by Fax.

Contact Name	Online Resources User Name if previously assigned	Subgroup(s) Access	Online Eligibility Select One		Billing Select One		Email Address required. Please add Fax Number if selecting Bill by Fax.
			View Only	Modify	E-Bill	Bill by Fax	

I _____, an authorized representative for _____, approve access to our account for the person(s) named above. I understand that it is the responsibility of our company to submit written notification to Delta Dental of Oklahoma if a user's access to Online Resources needs to be terminated.* Through the selection of the above options, I agree my company will receive our monthly bill from Delta Dental via the above selected option only.

Signature: _____ Date: _____

*A Group Change Form is available on Online Resources, and completed forms may be submitted to ClientRelations@DeltaDentalOK.org by a current authorized contact for your company.

Step 7 – BILLING AND PAYMENT OPTIONS

Billing Notification (select one): Online Resources – E-Bill (email notification) Fax Paper Bill

Payment Options (select one): Automatic Draft† FastPay™ online Pay-by-Phone Paper Check

†To set up automatic draft, please complete the information below. **A voided check must be attached to this authorization form.**

Contact Name Telephone Fax Email

Financial Institution Branch

Branch Address City State Zip

Branch Telephone

Select One: Checking Savings

I (We) _____ hereby authorize Delta Dental of Oklahoma and the financial institution named above to begin deductions of company dental premium from the account I have indicated herein on the fifth (5th) day of each month.* I understand that company eligibility can be placed on hold for a rejected draft.

Signature**: _____ Date: _____

*If the fifth (5th) day of the month is on a weekend or a holiday, Delta Dental of Oklahoma will debit the specified account on the next business day.

**Signature must be that of an authorized signer on the bank account.



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Step 8 – PRODUCER/AGENT/CONSULTANT INFORMATION

Producer/Agent/Consultant Name		Five Digit Broker Number
Agency		
City	State	Zip
Email Address	Telephone	Fax
Support Staff Name		
Support Staff Telephone Number		Support Staff Fax Number
Support Staff Email Address		

Producer/Agent/Consultant Fee Payment Options, if applicable: EFT to Producer/Consultant EFT to Agency

Step 9 – HOLD HARMLESS

Delta Dental has not reviewed the employer's request for plan coverage nor designed the group plan to meet any federal requirements for Discriminatory Employee Benefit Plans. Said plan may not be in compliance with criteria established for Discriminatory Employee Benefit Plans and employer holds Delta Dental Plan of Oklahoma harmless if said plan fails to meet any such requirements.

All information above is true and correct to the best of my knowledge.

I have reviewed and accept the benefits and eligibility requirements as stated in this Application for Group Contract and accept them.

Employer's Authorized Signature	
Title	Date
Producer/Agent/Consultant Signature	
Date	

Is the following included with this signed application? Enrollment Forms Electronic Enrollment data

Please ship my new group kit[†] to: Producer/Consultant Group Contact

[†]New group kit contains welcome letter, Plan Agreement, Summary Plan Description and identification cards.