APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – *Federally Compliant Plans (FCPs)*

For Plan Year 2024

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 – PLAN EFFECTIVE DATE: (Month) _____ 01, 2024

Step 2 – EMPLOYER INFORMATION

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

DBA (if applicable)

Billing/Mailing Address

City State Zip

Physical Oklahoma Address (if different from the billing/mailing address)

City State Zip

Telephone Number Nature of Business

Federal Tax ID Number SIC Code

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

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

Total Number Eligible Employees: _____

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*

Is the following included with this application? (select all that apply): ☐ Enrollment Forms ☐ Electronic Enrollment Data

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

Step 4 – EMPLOYER CONTRIBUTION

Employer contributes to the employee cost of the plan (select one): ☐ None ☐ A portion ☐ All

Step 5 – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Please provide a minimum of two (2) authorized group contacts, with a valid email address for each. A valid email address is required for each contact as our Federally Compliant plans are administered electronically. Enter the information for each contact that is to receive access through Online Resources, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance, invoice reporting and payment. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one (1) containing the User ID and another containing the temporary password.

Contact Type:

- **Primary Contact** – Authorized contact for all aspects of plan administration and recipient of essential plan correspondence, including plan documents, renewals, CDT changes, billing/delinquency notices, etc.
- **Secondary Contact** – Authorized contact for plan administration and recipient of plan correspondence in the event the Primary Contact cannot be contacted
- **Executive** – Authorized contact for all aspects of plan administration; should have access to billing and eligibility online.
- **Billing** – Authorized contact for billing inquiries; should have access to view and pay invoices online
- **Eligibility** – Authorized contact for eligibility and enrollment inquiries; should have access to enrollment online as indicated (view only or modify)

Eligibility Access:

- **View only** – Contact should have read-only access to online eligibility
- **Modify** – Contact should have ability to make changes through online eligibility

Primary Contact				Title		
Email				Telephone		
Contact Type (select one):	Billing	Eligibility	Executive	Eligibility Access (select one):	View only	Modify
Secondary Contact				Title		
Email				Telephone		
Contact Type (select one):	Billing	Eligibility	Executive	Eligibility Access (select one):	View only	Modify
Additional Contact				Title		
Email				Telephone		
Contact Type (select one):	Billing	Eligibility	Executive	Eligibility Access (select one):	View only	Modify
Additional Contact				Title		
Email				Telephone		
Contact Type (select one):	Billing	Eligibility	Executive	Eligibility Access (select one):	View only	Modify

An authorized representative for the Employer must approve access to information on this account for the person(s) named above, and for receipt of the monthly billing from Delta Dental via the above selected option. Further, the authorized representative for the Employer must submit written notification to Delta Dental of Oklahoma if a user's access to Online Resources needs to be terminated or access should be provided to additional persons. A Group Change Form is available on Online Resources and the authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.

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Step 6 – FULLY INSURED PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Plan Year: Calendar

MONTHLY RATES FOR *COMBINED* PLANS	Low Option	High Option
Ages 0 – 20 (Per Covered Person)	$30.00	$60.00
Ages 21 and older (Per Covered Person)	$30.00	$60.00

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*	Classes I, II and III Services Only	$75 per Person	n/a
Deductible per Plan Year – *Combined High*	Classes II and II Services Only	n/a	$50 per Person
Plan Maximum Year Benefit Payment – *for covered persons age 19 and older only*	Classes I, II and III Services Combined	$1,500	$1,500
Plan Benefit waiting Period(s) – *for covered persons age 19 and older only*	Class II Services	6 Months	6 Months
	Class III Services	12 Months	12 Months
Maximum Out-of-pocket Cost Per Benefit Plan Year – *for covered persons to age 19*	One Covered Person	$375	$375
	Two or more Covered Persons	$750	$750

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

Step 7 – THIRD PARTY ADMINISTRATORS

Third party administrators (TPA) listed in this section are authorized to conduct the specified business service(s) below on behalf of the employer group. The Employer authorizes DDOK to communicate and transact with the TPA, as needed, to fulfill applicable transactions and/or reporting.

EDI/Eligibility◊ _____

COBRA Administrator◊ _____

Flexible Spending Arrangement (FSA) Administrator_____

Other◊ _____

◊*TPAs acknowledging PHI/PII will be shared between the TPA and DDOK.*

I authorize DDOK to disclose Protected Health Information (PHI) and Personally Identifiable Information (PII), as defined in the Health Information Portability and Accountability Act of 1996, to the TPA listed above. I will maintain a signed Business Associate Agreement (BAA) for the above TPA authorization types identified as TPA(s) that acknowledge PHI/PII will be shared between the TPA and DDOK. At any time, DDOK reserves the right to request a copy of the signed agreement between the TPA and the Group listed on this application.

_____

Authorized Group Contact Name (please print or type) Title

_____

Authorized Group Contact Signature Date

Step 8 – PAYMENT OPTIONS

Designated Billing Contact(s) will be setup with monthly E-Bill reminders. Billing contact(s) may either log into Online Resources to view and pay invoice(s) or establish a monthly automatic draft. To set up automatic draft for the fifth (5th) day of each month*, please complete the information below. **A voided check must be attached to this authorization form.**

Financial Institution		Branch	
Branch Address	City	State	Zip
Branch Telephone			

Account Type (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 busine ss day.

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

Step 9 – PRODUCER/AGENT INFORMATION

Agency	**Five (5) Digit Agency Number**	**Telephone**
City	State	Zip
Producer/Agent Name	Email Address	Online Resources ID†
Producer/Agent Assistant Name	Email Address	Online Resources ID†
Second Servicing Producer/Agent Name	Email Address	Online Resources ID†

†If already assigned by DDOK

Step 10 – ACKNOWLEDGEMENT AND SIGNATURES

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.

By executing this Application For Group Contract, I hereby acknowledge all Federally Compliant employer plan documents and communications, including but limited to enrollee packets, group supplies, billing statements, and notices of renewal, delinquency and/or termination shall be provided electronically, and hereby consent to such delivery/administration. I understand such consent to electronic delivery/administration may be declined initially, or may be rescinded in the future by providing Delta Dental of Oklahoma written notice of such intent. Rescission effective date will be at least 30 days after written notice is received by Delta Dental of Oklahoma. I acknowledge failure to consent initially to electronic delivery/administration of the Federally Compliant group dental plan, or future rescission of consent to such, shall result in a $15.00 monthly paper delivery/administration fee, which shall be included in the monthly billing statements and payable under the same terms and conditions as the monthly premiums.

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. **Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Employer's Authorized Signature	Title	Date

Producer/Agent Signature	Date

New Group Kit

The new group kit will be emailed to the designated Primary Contact and Producer upon completion of new group implementation. The new group kit contains a welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.