APPLICATION FOR GROUP CONTRACT

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

For Plan Year **2025**

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, 2025**

Step 2 – EMPLOYER INFORMATION

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

Doing Business As *(DBA, if applicable)*

Billing/Mailing Address

City | State | Zip

Physical Oklahoma Address *(if different from 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 Eligible Employees is required for participation in Select. At least one (1) Eligible Employee must be enrolled in a plan option in order for that option to be available to the group.

Total Number Eligible Employees: _____

Step 4 – EMPLOYER CONTRIBUTION

Employer contribution 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 Select product is 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 and 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 the other 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

Additional contacts can be added, if necessary. Please include the name, title, email, telephone and contact type designation for each on a separate page and submit with the application. An authorized representative for the Employer approves the individuals/entities listed above and attached to access the indicated Protected Health Information and/or Personally Identifiable Information at Delta Dental of Oklahoma. As an authorized representative, I will notify Delta Dental of Oklahoma immediately in the event of termination of access of any of the individuals/entities listed above or attached. A Select Off-Renewal Plan Change Form is available via Online Resources on the Documents - Forms and Links page. An authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.

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)	$35.00	$72.00
Ages 21 and older (Per Covered Person)	$35.00	$72.00

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	$425	$425
	Two or more Covered Persons	$850	$850

*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◊ _____

I authorize Delta Dental of Oklahoma (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), where applicable *(marked with ◊)*, with the above identified TPA(s) that acknowledges 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) Title

_____

Authorized Group Contact Signature Date

Step 8 – PAYMENT OPTIONS

All designated Billing Contacts will receive an electronic monthly invoice via email, as well as automatic draft reminders, if applicable. Billing Contacts may remit payment via Automatic Draft or online, by logging into Online Resources to submit payment by credit card, checking or savings account each month.

Payment type (select one): Online Resources – move to step 9
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 Telephone

Branch Address | City | State | Zip | 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 business day.
**Signature must be that of an authorized signer on the bank account.

Step 9 – PRODUCER/AGENT INFORMATION

Agency	**Five 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 Delta Dental of Oklahoma

The Producer/Agency named in this form is authorized to request and approve designated business decisions/changes on behalf of the Group. The Group understands and agrees Delta Dental of Oklahoma (DDOK) shall communicate and transact with the named Producer/Agency, as needed, to complete applicable transactions.

Not Applicable – all decisions and/or changes must be communicated by an authorized group contact

Limited Authority – authorized to make the following decisions and/or changes on behalf of the employer group:

- Group Name Change
- Group Demographic Change
- Federal Tax Identification Number (TIN) Change
- Minimum Hours Worked
- New Hire Probationary Period
- Member/Dependent Term Rule
- Domestic Partnership Coverage
- Group Contact Change and/or Online Resources Access Update

Broad Authority – authorized to make Limited Authority decisions/changes, in addition to the following on behalf of the employer group:

- Benefit Year Change
- Contract/Anniversary Year Change
- Employer Contribution Change
- Division/Location Additions/Removals
- Change of Third-Party Administrator(s) (TPA)

Full Authority – authorized to make Broad Authority decisions/changes, in addition to the following on behalf of the employer group:

- Rate Tier Change
- Plan Type Addition/Removal
- Product Conversion
- Alternate Identification (Alt ID) Conversion
- Plan Design Change(s)
- Group Termination Requests
- Group Reinstatement Requests

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.

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.

Electronic Delivery/Administration: By executing this Application For Group Contract, I hereby acknowledge that: All Select employer plan documents, enrollee packets, group supplies, billing statements, and notices (renewal, delinquency, and/or termination) shall be provided electronically, and hereby consent to such delivery/administration. I understand that such consent to electronic delivery/administration may be declined initially, or rescinded in the future by providing Delta Dental of Oklahoma with written notice of intent to rescind such consent at least 30 days prior to the rescission effective date. Further, I acknowledge that failure to consent initially to electronic delivery/administration of the Select group dental plan or future rescission of consent 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.

Employer's Authorized Signature	Title	Date

Producer/Agent Signature	Date

NEW GROUP KIT

All Federally Compliant plan(s) documents, enrollee packets and group supplies will be provided electronically. The new group kit will be emailed to the designated Primary Contact and Producer upon completion of new group implementation and contains the welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.