APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – Group *26+*

For Plan Year **2023**

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, 2023

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 billing 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)*
Form 5500 information required? ☐Yes ☐No If Yes, reporting timeframe required: _____

Please provide a minimum of two (2) authorized group contacts. A valid email address is required for each contact. 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.

Contact Type:

- **Primary Contact** – Authorized contact for all aspects of plan administration and recipient of essential plan correspondence, including plan documents, renewals, CDT changes and billing/delinquency notices.
- **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
- **Eligibility –** Authorized contact for eligibility and enrollment inquiries

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 Group 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

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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 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 contact name, title, email, telephone and designate what contact type they should be (billing and/or eligibility) on a separate page and submit with this application. An authorized representative for the Employer approves access to information on this account for the persons named above, and to receive monthly invoice(s) via Online Resources. Furthermore, it is the responsibility of the Employer to submit written notification to Delta Dental of Oklahoma if a contact's access to the account or Online Resources should be terminated or changed. A Group 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 3 – FUNDING OPTIONS (select one): ☐ Fully Insured ☐ Self-Insured/Administrative Services Only (ASO)

Step 4 – ELIGIBILITY AND ENROLLMENT

A minimum of 10 enrolled or 25% of Eligible Employees, whichever is greater, required for participation in 26+ (only applies to fully insured groups).

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*

☐ This date determined by the Contractor or Plan Sponsor: ____________________*

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 5 – EMPLOYER CONTRIBUTION Employer contributes ____________ % **OR** $______________ to employee cost of plan.

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

Benefits Summary: Please indicate the applicable benefits information below by placing a checkmark in the appropriate box(es) and/or completing those areas requiring information, based on proposed benefits plan.

Plan Options:

- ☐ Single Option
- ☐ Dual Option
- ☐ Triple Option

Plan Types:

- ☐ Delta Dental PPO – Plus Premier
- ☐ Delta Dental PPO – Plus Premier "Elite"
- ☐ Delta Dental PPO – Point of Service
- ☐ Delta Dental PPO – Point of Service Advantage
- ☐ Delta Dental PPO
- ☐ Delta Dental PPO – Preventive Plus
- ☐ Delta Dental PPO – Choice Advantage

Covered Services and Plan Co-Insurance:	**PPO Network**	**Premier Network**	**Out-of-Network**
☐ Class I – Preventive and Diagnostic Services:	_____ %	_____ %	_____ %
☐ Class II – Basic Services:	_____ %	_____ %	_____ %
☐ Class III – Major Services:	_____ %	_____ %	_____ %
☐ Class IV – Orthodontic Services:	_____ %	_____ %	_____ %

☐ N/A ☐ Dependent Children Only ☐ Family **Deductible and Maximum** (select one)**:** ☐ Calendar Year ☐ Contract Year

Plan Year Deductible Per Person: _____ **Maximum Plan Year Deductible Per Family:** _____

Maximum Plan Year Benefit Payment, excluding Orthodontics: _____

Maximum Lifetime Orthodontic Benefit Payment, if applicable: _____

Additional Benefit Information, if applicable: _____

Monthly Rates – Fully Insured only (please indicate the appropriate rate structure and rates):

☐ Two-tier rate structure
Employee Only_____
Family_____

☐ Three-tier rate structure
Employee Only_____
Employee + One Dependent_____
Family_____

☐ Four-tier rate structure
Employee Only_____
Employee + Spouse_____
Employee + Children_____
Family_____

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 _____

FSA Administrator _____

Other _____

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Step 8 – BILLING AND PAYMENT OPTIONS

All designated Billing Contact(s) will be setup with monthly E-Bill notification emails, unless otherwise indicated. Billing Contact(s) may log into Online Resources to view invoice(s) and remit payment, as needed. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one containing the User ID and the other the temporary password.

Billing Notification **(select one)**: ☐ Online Resources – Detail E-Bill ☐ Paper Summary Bill

Payment Options **(select one)**: ☐ Automatic Draft† ☐ Online Resources FastPay™ ☐ Paper Check

†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 | 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

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.

Employer's Authorized Signature | Title | Date

Producer/Agent Signature | Date

New Group Kit

All Group 26+ employer plan 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 welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.