APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – *Select*

For Plan Year 2021

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)*

Billing/Mailing Address

City | State | Zip

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

City | State | Zip

Telephone Number

Type of Business

Federal Tax ID Number | SIC Code

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

Step 2 – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

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.

Contact Type:

- **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

Subgroup Access: Specify subgroup(s) contact is authorized to access; if contact should have access to all subgroups, please type 'ALL'

Group Executive | Title

Email | Telephone | Contact Type (select one): ☐ Billing ☐ Eligibility

Eligibility Access (select one): ☐ View only ☐ Modify | Subgroup Access

Step 2, continues on next page

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Step 2, continued from previous page – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Primary Contact Title

Email Telephone

Contact Type (select one): ☐ Billing ☐ Eligibility

Eligibility Access (select one): ☐ View only ☐ Modify

Subgroup Access

Additional Contact Title

Email Telephone

Contact Type (select one): ☐ Billing ☐ Eligibility

Eligibility Access (select one): ☐ View only ☐ Modify

Subgroup Access

Additional Contact Title

Email Telephone

Contact Type (select one): ☐ Billing ☐ Eligibility

Eligibility Access (select one): ☐ View only ☐ Modify

Subgroup Access

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.

Step 3 – PLAN EFFECTIVE DATE: (Month) _____ 01, 2021

Step 4 – 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 Employees: _____ Total Number Ineligible Employees: _____

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*

☐ The 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.**

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Step 5 – EMPLOYER CONTRIBUTION

Employer contributes (select one): ☐ None ☐ A portion ☐ All

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

2021 MONTHLY RATES	☐ Delta Dental PPO – Preventive Plus	☐ Delta Dental PPO	☐ Delta Dental PPO – Plus Premier	☐ Delta Dental PPO – Plus Premier "Elite"
Employee Only:	$23.00	$33.00	$46.00	$79.00
Employee + Spouse:	$46.00	$67.00	$92.00	$159.00
Employee + Child(ren):	$57.00	$83.00	$122.00	$206.00
Employee + Family:	$77.00	$112.00	$181.00	$294.00

BENEFITS SUMMARY

Delta Dental PPO – Preventive Plus

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	n/a
	Class IV – Orthodontic Services	n/a
Maximum Benefit Payment Per Person Per Calendar Year	Class I and II Services Combined	$750
Maximum Lifetime Benefit Payment Per Eligible Dependent Child	Class IV Services	n/a
Deductible Per Calendar Year	Class II Services Only	$50 Per Person

Delta Dental PPO

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	50%
	Class IV – Orthodontic Services	50%
Maximum Benefit Payment Per Person Per Calendar Year	Class I, II and III Services Combined	$1,500
Maximum Lifetime Benefit Payment Per Eligible Dependent Child	Class IV Services	$1,500
Deductible Per Calendar Year	Class II and III Services Only	$50 Per Person

Delta Dental PPO – Plus Premier

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	50%
	Class IV – Orthodontic Services	50%
Maximum Benefit Payment Per Person Per Calendar Year	Class I, II and III Services Combined	$1,500
Maximum Lifetime Benefit Payment Per Eligible Dependent Child	Class IV Services	$1,500
Deductible Per Calendar Year	Class II and III Services Only	$50 Per Person

Delta Dental PPO – Plus Premier "Elite"

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	50%
	Class IV – Orthodontic Services	50%
Maximum Benefit Payment Per Person Per Calendar Year	Class I, II and III Services Combined	$3,000
Maximum Lifetime Benefit Payment Per Eligible Person	Class IV Services	$2,000
Deductible Per Calendar Year	Class II and III Services Only	$50 Per Person

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Step 7 – PAYMENT OPTIONS

Designated Billing Contact(s) will be setup with monthly E-Bill notification emails and online payment access through the Online Resources portal.

To set up automatic draft, 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 business day.

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

Step 8 – PRODUCER/AGENT INFORMATION

Agency | **Five Digit Agency Number** | **Telephone**

City | State | Zip

Producer/Agent Name | Email Address

Producer/Agent Assistant Name | Email Address

Second Servicing Producer/Agent Name | Email Address

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

Step 9 – 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.

Employer's Authorized Signature | Title | Date

Producer/Agent Signature | Date

New Group Kit

All Select 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 the welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.