DELTA DENTAL

Group 26+
Off-Renewal Plan Change Request Form

DELTA DENTAL OF OKLAHOMA

Group Name: _____

Group Number: _____

Effective date: _____

Change(s) listed may be implemented for any first of the month, prospective effective date without impact to current premium rates.
Select applicable change(s) and complete the corresponding information.

☐ **Group Name Change**

Legal Business Name (as it should appear on Plan Agreement) Doing Business As (DBA, if applicable)

☐ **Group Demographic Change(s)**

Billing/Mailing Address

City State Zip

Physical Oklahoma Address *(if billing/mailing is a P.O. Box and/or different than physical address)*

City State Zip

Telephone Number

☐ **Federal Tax Identification Number (TIN) Change:** _____

☐ **Minimum Hours Worked –** Full-time employee means an employee who regularly works at least the number of hours in a normal work week set by the Contractor, but not less than _____ hours (not less than 30 hours is DDOK standard contract language).

☐ **New Hire Probationary Period** – Employees are eligible for coverage on (select one):

☐ Date of hire
☐ First of month following date of hire
☐ The ____ day of continuous full-time employment*
☐ First of the month following ____ days of continuous full-time employment*

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

☐ **Member Termination Rule**

Employees become ineligible for coverage on (select one):

☐ Date of termination ☐ End of month

Dependents reaching the age limitation become ineligible for coverage on (select one):

☐ Date threshold is exceeded ☐ End of month

☐ **Domestic Partnership** (select one):

☐ Eligible ☐ Not Eligible

☐ **Addition/Removal of Subgroup(s)/Division(s)** – Modifies account structure using existing plan offering(s). Enrollment forms are required.

☐ Add ☐ Remove Subgroup/Division Name

☐ Use Current Address ☐ Unique Subgroup/Division Address City State Zip

☐ Use Current Contacts ☐ Unique Subgroup/Division Contact(s) (complete Primary/Secondary contacts below):

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

☐ **Remove the following contact(s):**

Contact Name Email

Contact Name Email

☐ **Add the following contact(s):**

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

As an authorized representative for the above listed Group, I hereby authorize the selected change(s) to my organization's group dental benefits plan(s) to be implemented for the designated effective date. I understand it is the responsibility of the Group to submit written notification to Delta Dental of Oklahoma if account information and/or contact access should be changed or terminated.

Employer's Authorized Name (please print) Title

Employer's Authorized Signature Date

Submit Completed Forms to **ClientRelations@DeltaDentalOK.org** for processing.

Change(s) will be processed within five (5) business days of receipt and revised plan documents will be provided upon completion.

Should you have questions or need additional information, please contact your broker or our **Client Relations** team at **405-607-4777** (OKC Metro) or **866-503-4294** (Toll Free) Monday – Thursday 7:00 a.m. – 6:00 p.m. and Friday 7:00 a.m. – 5:00 p.m.