DELTA DENTAL

# Group 26+
# Renewal Change Request Form

DELTA DENTAL OF OKLAHOMA

**Group Name:** ______________________________

**Group Number:** ______________________________

**Anniversary Date:** ______________________________

## SECTION 1

Change(s) listed in Section 1 may be implemented for the plan anniversary date without impact to premium renewal rates, if submitted prior to or within the anniversary month. **Select applicable change(s) and complete the corresponding information.**

☐ **Benefit Year Change** – Plan year deductible(s) and maximum(s) renew on the first day of:
- ☐ January (calendar year benefits)
- ☐ ____________________________ each year (must coincide with anniversary date for contract year benefits)

☐ **Employer Contribution** – Employer contribution to the employee cost of the plan (select one): ☐ None ☐ A portion ☐ All

☐ **Alt ID Conversion** – Convert from Social Security Number (SSN) to Alternate Identification Number (Alt ID) for all eligible subscribers within a group. Minimum requirements include, but are not limited to:

- ☐ Alt ID and the SSN should be included for each subscriber to ensure claims and accumulator history remain intact.
- ☐ Group is responsible for providing Alt IDs in a format supported by DDOK, Alt IDs:
  - Must contain a minimum of six (6), but no more eight (eight) numeric digits
  - Have a maximum of 15 characters
  - Alpha characters must precede numeric characters (e.g., ABCDEFG12345678)
  - Cannot be or contain an SSN
  - Must be unique and cannot currently exist in the DDOK system
    - If an Alt ID supplied is currently in use within the DDOK system, the group will be notified and is responsible for providing another Alt ID for the impacted subscriber.
  - Alt ID or SSN may be used for any communication between the group and DDOK regarding subscribers and their eligible dependents, including but not limited to the weekly eligibility file, Online Resources and monthly invoicing.
  - Alt ID or SSN may be used for any communication between the member, provider and DDOK regarding subscribers and their eligible dependents, including but not limited to eligibility verification, benefit inquiries and claims submission.

*Section 1 change(s) will process within 30 days of your anniversary or five (5) business days of receipt, if received within the renewal month. Revised plan documents will be provided upon completion.*

## SECTION 2

Change(s) listed in Section 2 may be implemented for the plan anniversary date, if submitted prior to or within the anniversary month *and* approved by DDOK Underwriting Department. If the requested change(s) impact premium renewal rates, you will receive a Renewal Option Page for review and signature. **Select applicable change(s) and complete the corresponding information.**

☐ **Anniversary Date Change** – Plan Agreement and premium rates renew on the first day of ____________________________ each year.

☐ **Rate Tier Change** – Please indicate the appropriate monthly rate structure:

☐ Two-tier rate structure ☐ Three-tier rate structure ☐ Four-tier rate structure

☐ **Product Conversion** – Please indicate the desired plan(s) to **replace** current plan offering(s). Enrollment forms are required with signed Renewal Option Form.

**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

## SECTION 2 (Continued)

☐ **Addition/Removal of Plan Type(s)** – Please indicate the desired plan(s) to be added to or removed from the current plan offering(s). Enrollment forms are required.

**Plan Types:**

Delta Dental PPO – Plus Premier: ☐ Add ☐ Remove
Delta Dental PPO – Plus Premier "Elite:" ☐ Add ☐ Remove
Delta Dental PPO – Point of Service: ☐ Add ☐ Remove
Delta Dental PPO – Point of Service Advantage: ☐ Add ☐ Remove
Delta Dental PPO: ☐ Add ☐ Remove
Delta Dental PPO – Preventive Plus: ☐ Add ☐ Remove
Delta Dental PPO – Choice Advantage: ☐ Add ☐ Remove

☐ **Plan Design Change** – Please indicate the desired covered service and/or co-insurance structure to modify the existing plan offering(s):

| **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: | ______% | ______% | ______% |

☐ Dependent Children Only ☐ Family

Endodontics, periodontics and oral surgery are payable as: ☐ Class II Services ☐ Class III Services

☐ **Deductible(s) and/or Maximum(s) Change:**

**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: ______________________________________________**

☐ **Broker Commission Change:**

Fully Insured Plans: ☐ Percent of Premiums _____% ☐ No Commission
Self-Funded Plans: ☐ Per Employee Per Month $_____ ☐ Percent of Paid Claims ____% ☐ No Commission

*Section 2 change(s) will be reviewed by Underwriting within five (5) business days. Renewal Option(s) will be provided for an authorized group contact to review and approve at that time. Upon receipt of signed Renewal Option(s), plan change(s) will queue for processing within 30 days of your anniversary or five (5) business days of receipt, if received within the renewal month. Revised plan documents will be provided upon completion.*

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 requested anniversary 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 change or be terminated.

______________________________________________________________
Employer's Authorized Name (please print) Title

______________________________________________________________
Employer's Authorized Signature Date

Submit Completed Forms to ClientRelations@DeltaDentalOK.org. 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.