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APPLICATION FOR ADMINISTRATIVE SERVICES AGREEMENT

Delta Dental of Oklahoma – Self-Funded Plans

This Application for Group Contract is hereby made a part of the Administrative Services Only 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: _____ 01, 20 ____
(month)

Step 2 – EMPLOYER INFORMATION (*as filed with the Oklahoma Tax Commission)*

Legal Business Name (as it should appear on Summary Plan Description and Administrative Services Only Agreement)

Doing Business As (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? ☐No ☐Yes If Yes, reporting timeframe required: _____

Please provide a minimum of two (2) authorized group contacts, with a valid email address for each. Enter the information for each contact who is to receive access through Online Resources, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance, as well as enrollment and claims reporting. 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 contact changes, 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. Authorized to submit regular updates to contact list.
- **Group/All** – Authorized group contact for all aspects of plan administration and recipient of plan correspondence.
- **Group/Eligibility** – Authorized group contact for eligibility/enrollment administration. Authorized to submit and receive eligibility/enrollment additions, modifications, terminations and/or reports.
- **Group/Billing** – Authorized group contact for billing/payment administration. Authorized to submit and receive billing/payment correspondence and/or reports.

Access Status:

- **All PHI/PII** – Authorized contact for all aspects of plan administration, including but not limited to billing, eligibility, claims and reporting inquiries.
- **Eligibility Only** – Authorized contact for eligibility and enrollment reporting and inquiries.
- **COBRA Eligibility Only** – Authorized contact for COBRA eligibility and enrollment reporting and inquiries.
- **Contact Change Authority** – Authorized contact for group contact additions, changes and/or removals.
- **Ebill** – Authorized contact for electronic billing (Ebill) correspondence.
- **ASO Reporting** – Authorized contact to receive all ASO reporting, including but not limited to eligibility/enrollment and claims.

Online Resources Access:

- **Read Eligibility** – Contact should have read-only access to online eligibility.
- **Modify Eligibility** – Contact should have ability to make changes through online eligibility.
- **Claims** – Contact should have ability to view/download online claims reports.

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Additional contacts can be added, if necessary. Please include the name, title, email, telephone and contact type designation for each on the Authorized Contact List for Administrative Services Only Plans and submit with the application. An authorized representative for the Employer approves the individuals/entities listed below 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 below or attached. I acknowledge requests for updates to this form must be made in writing to ClientRelations@DeltaDentalOK.org.

Primary Group Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): ☐ Group/All ☐ Group/Eligibility ☐ Group/Billing ☐ Consultant ☐ TPA ☐ TPA – COBRA

Access Status (select applicable): ☐ All PHI/PII ☐ Eligibility Only ☐ COBRA Eligibility Only ☐ Contact Change Authority ☐ Ebill ☐ ASO Reporting

Online Resources Access (select applicable): ☐ Read-only Eligibility ☐ Modify Eligibility ☐ Claims ☐ Not Applicable

Secondary Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): ☐ Group/All ☐ Group/Eligibility ☐ Group/Billing ☐ Consultant ☐ TPA ☐ TPA – COBRA

Access Status (select applicable): ☐ All PHI/PII ☐ Eligibility Only ☐ COBRA Eligibility Only ☐ Contact Change Authority ☐ Ebill ☐ ASO Reporting

Online Resources Access (select applicable): ☐ Read-only Eligibility ☐ Modify Eligibility ☐ Claims ☐ Not Applicable

Additional Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): ☐ Group/All ☐ Group/Eligibility ☐ Group/Billing ☐ Consultant ☐ TPA ☐ TPA – COBRA

Access Status (select applicable): ☐ All PHI/PII ☐ Eligibility Only ☐ COBRA Eligibility Only ☐ Contact Change Authority ☐ Ebill ☐ ASO Reporting

Online Resources Access (select applicable): ☐ Read-only Eligibility ☐ Modify Eligibility ☐ Claims ☐ Not Applicable

Additional Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): ☐ Group/All ☐ Group/Eligibility ☐ Group/Billing ☐ Consultant ☐ TPA ☐ TPA – COBRA

Access Status (select applicable): ☐ All PHI/PII ☐ Eligibility Only ☐ COBRA Eligibility Only ☐ Contact Change Authority ☐ Ebill ☐ ASO Reporting

Online Resources Access (select applicable): ☐ Read-only Eligibility ☐ Modify Eligibility ☐ Claims ☐ Not Applicable

Additional Contact Title Organization (if different than group)

Email Telephone

Contact Type (select applicable): ☐ Group/All ☐ Group/Eligibility ☐ Group/Billing ☐ Consultant ☐ TPA ☐ TPA – COBRA

Access Status (select applicable): ☐ All PHI/PII ☐ Eligibility Only ☐ COBRA Eligibility Only ☐ Contact Change Authority ☐ Ebill ☐ ASO Reporting

Online Resources Access (select applicable): ☐ Read-only Eligibility ☐ Modify Eligibility ☐ Claims ☐ Not Applicable

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Step 3 – ELIGIBILITY AND ENROLLMENT

Total Number Eligible Employees (*as reported to the Oklahoma Employment Security Commission*): _____

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

Employees become ineligible for coverage on (select one)**:**

☐ Date of termination ☐ End of month ☐ End of pay period ☐ 30 days after termination

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

☐ Date threshold is exceeded ☐ End of month threshold is exceeded ☐ End of year threshold is exceeded

Domestic Partnership (select one)**:** ☐ Eligible ☐ Not Eligible

Retirees (select one)**:** ☐ Covered by Group Plan ☐ DDOK Retiree Conversion Plan ☐ Not Applicable

Enrollment/Eligibility Processing

Initial Implementation (select one): ☐ EDI* File ☐ One-Time Load ☐ Online Resources ☐ Enrollment Forms

Ongoing Maintenance (select applicable): ☐ EDI* File ☐ Online Resources ☐ Enrollment Forms

**Minimum of 75 subscribers required to use this method.*

Subscriber Identification Number (select one)**:** ☐ SSN ☐ Alternate Identification Numbers (Alt IDs)

Note: *Implementation of Alternate Identification Numbers (Alt IDs) requires 90 days for testing and must meet Delta Dental of Oklahoma's requirements.*

Step 4 – EMPLOYER CONTRIBUTION Employer contributes _____% **OR** $_____ to employee cost of plan.

Step 5 – 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*

**Ask your dentist if he/she is a Delta Dental PPO participating dentist or verify their network participation prior to enrollment at DeltaDentalOK.org/DentistSearch*

Account Structure (select one): ☐ One Subgroup per Plan Option ☐ Other (Details Attached)

Processing Policy: ☐ DDOK Standard ☐ Current Carrier Match *(benefit breakdown required)* ☐ Other *(benefit breakdown required)*

Health through Oral Wellness® (HOW®): ☐ Accepted ☐ Declined

Covered Services and Plan Co-Payment:	**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

Deductible(s) and Maximum(s): Plan Year Deductible(s) and Maximum(s) renew _____ (month) 01, each year.

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

Maximum Plan Year Benefit Payment: _____ ☐ Excluding Orthodontics ☐ Including Orthodontics

Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will reduce Annual Maximum Plan Year Benefit (select one): ☐ Yes ☐ No

Maximum Lifetime Orthodontic Benefit Payment, if applicable: _____

Maximum Dependent Age: _____

Additional Benefit Information, if applicable: _____

Tier Structure – (please indicate the appropriate tier structure):

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

Step 6 – REIMBURSEMENT SCHEDULES AND PAYMENT OPTIONS

Claims reimbursement schedule is weekly and Administrative Fee payment schedule is monthly, unless otherwise approved and agreed upon in writing with the signed proposal and receipt of Operating Fund Deposit. Designated Contact(s) will receive claims/administrative fee invoices via email from Accounting@DeltaDentalOK.org according to this schedule.

Claims Reimbursement (select one): ☐ Automatic Draft ☐ Wire Transfer

Indicate alternate frequency and deposit amount here (if applicable): _____

Administrative Fees (please indicate the appropriate fee structure): ☐ Per Employee Per Month $____ ☐ Percent of Paid Claims ____ %

Administrative Fee Payment (select one): ☐ Automatic Draft† ☐ Wire Transfer ☐ Check

†To set up automatic draft for claims and/or administrative fees, please complete the information below. Drafts occur a minimum of two (2) days after the claims and/or administrative fee invoices are issued. **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 claims reimbursements and/or administrative fees from the account I have indicated herein. I understand that company claims can be placed on hold for a rejected draft.

Signature**: _____ Date: _____

*If the date claims and/or administrative fee invoices are issued falls on 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 7 – THIRD PARTY ADMINISTRATORS

Third party administers (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. **All TPAs must also be listed on the 'Authorized Contact List for Administrative Services Only Plans' as a TPA, with access type designated.**

EDI/Eligibility◊ _____ email _____ phone _____

COBRA Administrator◊ _____ email _____ phone _____

Flexible Spending Arrangement (FSA) Administrator _____ email _____ phone _____

Other◊ _____ email _____ phone _____

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◊, 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

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Step 8 – 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.

Producer Commission (as approved and noted on signed proposal; select one):

☐ **Per Employee Per Month $** _____ ☐ **Percent of Paid Claims** _____**%** ☐ **No Commission**

Step 9 – DOCUMENTS AND FULFILLMENT

New Group Kit

All self-funded 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, Administrative Services Agreement, Summary Plan Description*, electronic identification cards and, if applicable, Retiree Conversion materials.

*Summary Plan Description (SPD) written by:

☐ **Delta Dental of Oklahoma** ☐ **Group** (please provide a copy of the current dental benefits SPD for DDOK records)

New Enrollee Packet

Initial Implementation (select one)

☐ Electronic to Group ☐ Mail to Group ☐ Mail to Subscriber

Ongoing Maintenance (select one)

☐ Electronic to Group ☐ Mail to Group

Step 10 – ACKNOWLEDGEMENT AND SIGNATURES

Though providing certain administrative services to the employer, Delta Dental has not reviewed the employer's group plan coverage nor designed the employer's group plan to meet any federal requirements that may apply for Discriminatory Employee Benefit Plans. Said self-funded group plan may not be in compliance with criteria established for such 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 Administrative Services Only (ASO) Agreement. **Be advised:** 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 ASO Agreement, I hereby acknowledge that: All ASO 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 ASO 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