DELTA DENTAL®

SELF-FUNDED GROUPS

Administrative Services Only (ASO)

DELTA DENTAL OF OKLAHOMA

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Implementation Checklist for Administrative Services Agreement

When establishing a new Administrative Services Only (ASO) plan, there are several essential documents necessary for an efficient implementation. To better serve our clients, DDOK has developed a checklist for the ASO plan setup and initial enrollment process.

☐ Application for Administrative Services Agreement

- ☐ **Step 1**: Plan Effective Date
- ☐ **Step 2**: Employer Information
- ☐ **Step 3**: Eligibility and Enrollment
- ☐ **Step 4**: Employer Contribution
- ☐ **Step 5**: Plan Options and Plan Selection
- ☐ **Step 6:** Reimbursement Schedules and Payment Options ***(Authorized Bank Signature Required)***
- ☐ **Step 7**: Third Party Administrators ***(Authorized Contact Signature Required)***
- ☐ **Step 8**: Producer/Agent Information
- ☐ **Step 9:** Documents and Fulfillment
- ☐ **Step 10:** Acknowledgement and Signatures

Please note: *Incomplete and/or inaccurate applications will result in processing delays. Please ensure the application is completed in its entirety and signed by the person authorized to contract for the group and, if applicable, producer.*

☐ Statement of HIPAA Certification – Completed and signed by Chief Privacy Officer

☐ Plan Certification of HIPAA Compliance – Completed and signed by Chief Privacy Officer

☐ Initial Enrollment (select one):

- ☐ **Enrollment Forms** – PDF forms completed and signed by each employee
- ☐ **One-Time Load** – Use the specifications on the 'Instructions' tab of the formatted Excel spreadsheet to capture all member elections
- ☐ **EDI File** – Weekly 834 Electronic Data Interchange (EDI) file with all active enrollments, changes and/or terminations (minimum of 75 subscribers required to use this method). A member of our Electronic Services team will contact you to begin file implementation and testing once account structure is established.

☐ ASO Contact List (if needed for additional contacts)

Send completed application, enrollment documents and HIPAA certifications electronically to Sales@DeltaDentalOK.org or by mail to:

Delta Dental of Oklahoma
Attention: Sales
P.O. Box 54709
Oklahoma City, Oklahoma 73154-1709

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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.

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

DELTA DENTAL

Statement of HIPAA Certification for Administrative Services Agreement

DELTA DENTAL OF OKLAHOMA

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and amendments thereto regarding the Privacy and Security of Protected Health Information and Electronic Protected Health Information (collectively 'PHI'), which is to include Genetic Information as defined by the Genetic Information Nondiscrimination Act (GINA) § 105(a) and corresponding federal regulations, _____ the '**Plan Sponsor**,' at _____ _____[Address], hereby makes the following certification to **Delta Dental of Oklahoma** (DDOK) as to its compliance with the rules and regulations governing PHI in relation to, _____ [**Name of Plan**] otherwise known as 'The **Plan**.'

1. The Plan Sponsor will NOT use or further disclose PHI other than as permitted or required by the Plan documents, or as required by law.
2. The Plan Sponsor ensures that every agent, including any subcontractor, to whom the Plan Sponsor provides PHI, is bound by the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.
3. The Plan Sponsor will NOT use or disclose PHI for employment-related actions and decisions or in connection with any other benefits or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan and to DDOK any use or disclosure of the PHI that is inconsistent with the uses and disclosures provided for in the Plan documents, of which it becomes aware.
5. The Plan Sponsor will ensure that each participant, dependent, personal representative or enrollee will have access to his/her PHI maintained by the Plan Sponsor.
6. The Plan Sponsor will ensure that each participant, dependent, personal representative or enrollee will have the ability to amend or incorporate any amendments to his/her PHI, if said amendment is proper according to the Plan's HIPAA compliance documents and/or HIPAA itself.
7. The Plan Sponsor will ensure that PHI and its disclosure and use is appropriately maintained in a manner consistent with the Plan documents and rules governing HIPAA, so that an accounting may be provided to the individual.
8. The Plan Sponsor will make available to the Secretary of the Department of Health and Human Services, and other regulatory agencies having the appropriate authority, the Plan and Plan Sponsor internal practices, books, and records relating to the use and disclosure of PHI received from DDOK, for the purpose of determining compliance by DDOK with HIPAA.
9. If feasible, upon the termination of the plan, or any arrangement with DDOK, the Plan Sponsor will return or destroy all PHI received from DDOK that the Plan Sponsor continues to maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further use and disclosure to those purposes that make the return or destruction of the PHI infeasible.

The person signing this Certification has the authority, on behalf of the Plan Sponsor to make the affirmations of compliance found in this Certification and will hold DDOK harmless in the event any of the compliance statements are found to be incorrect, have been inappropriately implemented, or have been violated by Plan Sponsor.

_____ _____

Chief Privacy Officer Signature | Date

_____ _____

Typed or Printed Name | Delta Dental Group Number

Please complete, sign and date this Certification, and return one (1) original to Delta Dental of Oklahoma.

DELTA DENTAL

Certification of HIPAA Compliance for Administrative Services Agreement

DELTA DENTAL OF OKLAHOMA

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and amendments thereto regarding the Privacy and Security of Protected Health Information and Electronic Protected Health Information (collectively 'PHI'), which includes genetic information as defined by the Genetic Information Nondiscrimination Act (GINA) § 105(a) and corresponding federal regulations, the _____ [**Name of Plan**], otherwise known as 'The **Plan**,' hereby certifies its compliance to **Delta Dental of Oklahoma** (DDOK) with the rules and regulations governing PHI as follows:

1. The Plan and the Plan Sponsor have created an adequate separation between the Plan and the Plan Sponsor that is compliant with the rules and regulations governing HIPAA.
2. The Plan documents include a description of those employees or classes of employees or other persons under the control of the Plan Sponsor to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, must be included in this description.
3. The Plan documents adequately restrict access to and use by the employees and other persons for plan administration functions that the Plan Sponsor performs for the Plan.
4. The Plan documents provide an effective mechanism for resolving issues of noncompliance by Plan Sponsor personnel or others having access to Plan participant's PHI.
5. The Plan documents DO NOT permit DDOK to disclose PHI to the Plan Sponsor except as permitted.
6. The Plan documents prohibit the disclosure of PHI to the Plan Sponsor otherwise permitted by these policies and procedures, unless these disclosures are made part of the Notice of Privacy Practices of the Plan.
7. The Plan documents prohibit any disclosure or use of PHI by the Plan Sponsor for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
8. The Plan documents of the Plan have been amended to incorporate provisions to require the Plan Sponsor to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
9. Any agent, including a subcontractor, to whom the Plan provides PHI, agrees to implement reasonable and appropriate security measures to protect the PHI.
10. The Plan will promptly report to Delta Dental of Oklahoma any security incident of which it becomes aware.

_____	_____
Plan Sponsor (Name of Company)	Date
_____	_____
Chief Privacy Officer Signature	Delta Dental Group Number
_____	
[Address]	***Please complete, sign and date this Certification, and return one (1) original to Delta Dental of Oklahoma.***
_____	

Confidentiality Notice: *This documentation may contain personal, confidential and privileged information that is otherwise protected by law. If you are not the intended recipient, do not read, copy, distribute, use or disclose any of the information or documentation to other parties. If you have received this document in error, please notify the Delta Dental of Oklahoma Compliance Department at Compliance@DeltaDentalOK.org, 800-522-0188 or 405-607-2100 and destroy all documents received in error.*

Enrollment/Eligibility Update

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PLAN TYPE:
(AS ESTABLISHED BETWEEN EMPLOYER AND DELTA DENTAL)

- ☐ DELTA DENTAL PPO
- ☐ DELTA DENTAL PPO – PREVENTIVE PLUS
- ☐ DELTA DENTAL PPO – PLUS PREMIER
- ☐ DELTA DENTAL PPO – PLUS PREMIER "ELITE"
- ☐ DELTA DENTAL PPO – CHOICE
- ☐ DELTA DENTAL PPO – CHOICE ADVANTAGE
- ☐ DELTA DENTAL PPO – POINT OF SERVICE

Employer: _____ GROUP# _____ SUBGROUP# _____ LOCATION CODE _____

Subscriber Information: *(please complete in ink for enrollment/eligibility updates)*

SUBSCRIBER NAME (LAST)		(FIRST)		
SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE	STATUS ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving Dep. ☐ Other: _____
ADDRESS				
CITY	STATE	ZIP	☐ CHECK IF THIS IS A NEW ADDRESS	

EMAIL: _____

Enrollment/Eligibility Update Information – EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION:

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:
☐ NEW ENROLLMENT ☐ REINSTATEMENT ☐ OPEN ENROLLMENT
☐ COBRA ELECTION ☐ TERMINATION OF BENEFITS
☐ TERMINATION OF EMPLOYMENT AS OF _____

☐ CHANGE IN CURRENT ENROLLMENT STATUS FOR ☐ SUBSCRIBER ☐ DEPENDENTS
REASON FOR CHANGE:
☐ DIVORCE ☐ MARRIAGE ☐ NAME CHANGE ☐ LEGAL GUARDIANSHIP
☐ ADOPTION ☐ OTHER _____

GROUP TRANSFER FROM GROUP# _____ SUBGROUP# _____ TO GROUP# _____ SUBGROUP# _____

Dependent Enrollment/Eligibility Update Information: (please complete for spouse and/or dependent children for enrollment/eligibility update)

SPOUSE NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE
DEPENDENT CHILD NAME (LAST)	(FIRST)	BIRTH DATE

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete or missing information is guilty of a felony.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma, and acknowledge I have read the privacy policy detailed via the links below.

☐ By checking this box as the enrollee, you confirm explicit consent regarding Delta Dental of Oklahoma's collection, use, disclosure, maintenance, storage, and disposal of Customer Protected Health Information and Personally Identifiable Information as described in the enrollment form's Privacy Policy online at DeltaDentalOK.org/PrivacyPolicyGroup, or by mail upon request, and Delta Dental of Oklahoma's Notice of Privacy Practices available at DeltaDentalOK.org/HIPAANotice, or by mail upon request.

Subscriber Signature: _____ Date: _____

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Authorized Contact List for Administrative Services Only Plans

DELTA DENTAL OF OKLAHOMA

Group/Plan Name: _____

Group Number: _____

Please 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 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 contracted. 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.

Additional Contact Title Organization (if different than Group/Plan)

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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Additional Contact Title Organization (if different than Group/Plan)

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/Plan)

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/Plan)

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/Plan)

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

As an authorized representative for the above referenced Group/Plan, I approve the individuals/entities listed above 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 above. I acknowledge requests for updates to this form must be made in writing to ClientRelations@DeltaDentalOK.org.

Primary/Secondary/Executive Employer Contact Name (please print) Title

Primary/Secondary/Executive Employer Authorized Signature Date

DELTA DENTAL®

DELTA DENTAL OF OKLAHOMA
ONLINE RESOURCES

At **Delta Dental of Oklahoma (DDOK)**, we pride ourselves on providing our clients with the tools they need to efficiently administer dental benefits to their company and employees.

Online Resources, our portal for group administrators, allows designated persons within your organization, or your broker, to securely access information for your group.

Features include:

Eligibility Maintenance

Provides group administrators with direct access to review and maintain eligibility for their employees.

Explanation of Benefits Access

Self-funded clients can download and/or print Explanation of Benefits (EOBs) for any enrollee.

Secure Messaging

Group Administrators may contact DDOK securely through our Secure Messaging portal.

ASO Reporting

Clients who elect to contract with DDOK on an Administrative Services Only (ASO) basis have access to our Online Reporting feature to self-generate the following reports:

- Claims by class, group, relationship and subgroup
- Covered lives
- Network utilization
- Overage dependent
- Subscriber list
- Claims lag
- Eligibility lookup

To learn more about Online Resources, please visit DeltaDentalOK.org/OnlineResources

DELTA DENTAL®

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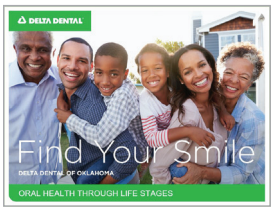
ADDITIONAL ACCOUNT SERVICES

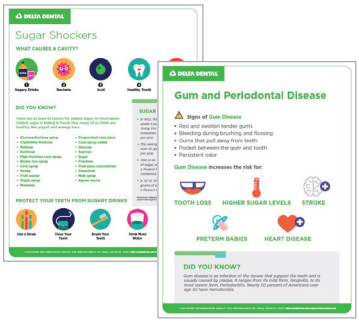


Oral Wellness

Onsite Presentations and/or Live Q&A
for groups with 50+ enrollees

DDOK will make an onsite visit to present oral wellness information and tips to maintain a healthier life. The presentation is open to all employees and focuses on key points about oral wellness.

A live question and answer (Q&A) session with a DDOK Account Manager may be added to the presentation or requested as a standalone event.



Onsite Screenings
for groups with 100+ enrollees

We set up private screening kiosks at health fairs and enrollment events and provide pain-free oral health assessments conducted by a registered dental hygienist.

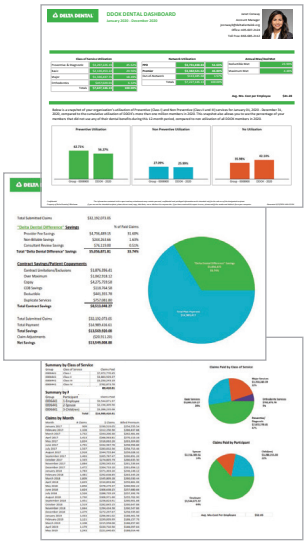
Oral-B Pro 3000 Bundle Giveaway
for groups with 250+ enrollees

Encourage employees to use their DDOK preventive care benefits. Eligible employees receiving preventive care are entered into a drawing to win an oral health care package including an Oral-B Pro 3000 electric toothbrush, full-size toothpaste and mouthwash.

Retiree Conversion Program

Through our Retiree Conversion Program, DDOK works with retiring employees to provide a simple process to continue their dental benefits at no cost to your group.

Annual Reporting
for groups with 100+ enrollees



Network Utilization Reports

DDOK provides a summary report of network utilization giving you information on employee network access and effectiveness of subscriber savings within our networks.

Cost Management Reports

Clients receive a summary report of savings based on plan payment data. This report identifies the actual dollar amount you save annually by accessing Delta Dental participating providers.

Dental Claims Activity

Annual claims reporting shows a comprehensive breakdown of claims submitted. Provides a summary of claims paid by class of service, participant, and month. Also provides plan enrollment by month, and an average monthly cost per employee.

For more information, contact your Account Manager.

DELTA DENTAL®

Boost Your Benefits

Check out HOW®

Available Now!

Delta Dental of Oklahoma is dedicated to advancing the oral wellness of our members. We recognize each member is unique, and some may need additional services in order to achieve optimal oral health.

Health *through* Oral Wellness® (HOW®) enhanced benefits are designed to boost members existing Delta Dental plan with additional preventive benefits, if they are at higher risk for developing caries and/or periodontal disease.*

*based on the results of the HOW® approved assessment performed in a dental office

For more information, visit
DeltaDentalOK.org/HOW

DELTADENTALOK.ORG