DELTA DENTAL

For Delta Dental of Oklahoma Use Only:
Group No. _____

APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – *Federally Compliant Plans (FCPs)*

For Plan Year 2018

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 Address

City | State | Zip

Physical Address (if different from the billing address)

City | State | Zip

Telephone Number | Fax Number

Website Address

Type of Business

Federal Tax ID Number | SIC Code

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

Group Executive | Title

Email | Telephone | Fax

Primary Group Contact | Title

Email | Telephone | Fax

Billing Contact | Title

Email | Telephone | Fax

Eligibility Contact | Title

Email | Telephone | Fax

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Step 2 – PLAN EFFECTIVE DATE: (Month): _____ (Day): _____, 2018

Step 3 – ELIGIBILITY AND ENROLLMENT: A minimum of two (2) enrolled Eligible Employees required for participation in Combined FCP(s).

Total Number Employees: _____ Total Number Ineligible Employees*: _____

Total Number Eligible Employees: _____

***Indicate Reason(s) for Ineligibility** _____

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*

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.

Step 4 – FULLY INSURED PLAN OPTIONS AND PLAN SELECTION (select all that apply)

Plan Year: Calendar

MONTHLY RATES FOR *COMBINED* PLANS	☐ **Low Option**	☐ **High Option**
Ages 0 – 20 (Per Covered Person)	$20.00	$33.00
Ages 21 and older (Per Covered Person)	$20.00	$33.00

MONTHLY RATES FOR *PEDIATRIC* PLANS (must be under age 19)	☐ **Low Option**	☐ **High Option**
One Covered Person	$20.00	$33.00
Two Covered Persons	$40.00	$66.00
Three or more Covered Persons	$60.00	$98.00

BENEFITS SUMMARY		**Low Options**	**High Options**
Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%	100%
	Class II – Basic Services	60%	80%
	Class III – Major Services	50%	50%
	Class IV – Orthodontic Services*	50%	50%
Deductible per Plan Year – *Combined Low and Pediatric Low*	Class I, II and III Services Only	$75 per Person	n/a
Deductible per Plan Year – *Combined High and Pediatric High*	Class II and II Services Only	n/a	$50 per Person
Plan Maximum Year Benefit Payment – *for covered persons age 19 and older only*	Class I, II and III Services Combined	$1,500	$1,500
Plan Benefit Limitation Period(s) – *for covered persons age 19 and older only*	Class II Services	6 Months	6 Months
	Class III Services	12 Months	12 Months
Maximum Out of Pocket Cost Per Benefit Plan Year – *for covered persons to age 19*	One Covered Person	$350	$350
	Two or more Covered Persons	$700	$700

*Medically Necessary Only for Covered Person(s) to age 19

Step 5 – EMPLOYER CONTRIBUTION

Employer Contributes _____% **OR** $ _____ to **employee** cost of plan.

Employer Contributes _____% **OR** $ _____ to **dependent** cost of plan.

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Step 6 – OPTIONS FOR ACCESS TO ONLINE RESOURCES

Enter the information for each contact that is to receive online access through Online Resources. If a contact should have access to all subgroups then enter "ALL" in the Subgroup(s) Access box. Select each type of access. You may choose one method of invoice receipt, E-Bill or Bill by Fax.

An email address is required for each contact requesting access to Online Resources.

Subgroup Access: Name the contact(s) who will receive access to the specified subgroup(s).

Online Eligibility: Name the contact(s) who will receive access to *view and/or modify* eligibility in Online Resources.

View Only: Read-only access to online eligibility. **Modify:** Ability to make changes through online eligibility.

Billing: Name the contact(s) who will receive access to billing.

E-Bill: Access to receive the invoice through email. **Bill by Fax:** Access to receive the invoice by Fax.

Contact Name	Online Resources User Name if previously assigned	Subgroup(s) Access	Online Eligibility **Select One**		Billing **Select One**		Email Address required. Please add Fax Number if selecting Bill by Fax.
			View Only	Modify	E-Bill	Bill by Fax	

I _____, an authorized representative for _____, approve access to our account for the person(s) named above. I understand that it is the responsibility of our company to submit written notification to Delta Dental of Oklahoma if a user's access to Online Resources needs to be terminated.[+] **Through the selection of the above options, I agree my company will receive our monthly bill from Delta Dental via the above selected option only.**

Signature: _____ Date: _____

[+]A Group Change Form is available on Online Resources, and completed forms may be submitted to ClientRelations@DeltaDentalOK.org by a current authorized contact for your company.

Step 7 – BILLING AND PAYMENT OPTIONS

Billing Notification (select one): ☐ Online Resources – E-Bill (email notification) ☐ Fax ☐ Paper Bill

Payment Options (select one): ☐ Automatic Draft[†] ☐ FastPay™ online ☐ Pay-by-Phone ☐ Paper Check

[†]To set up automatic draft, please complete the information below. **A voided check must be attached to this authorization form.**

Billing Contact | Telephone | Fax | Email

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 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.

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Step 8 – PRODUCER/AGENT/CONSULTANT INFORMATION

Producer/Agent/Consultant Name **Five Digit Broker Number**

Agency

City State Zip

Email Address Telephone Fax

Support Staff Name

Support Staff Telephone Number Support Staff Fax Number

Support Staff Email Address

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

Step 9 – HOLD HARMLESS

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 and accept them.

Employer's Authorized Signature

Title Date

Producer/Agent/Consultant Signature Date

Please ship my new group kit[†] to: ☐ **Producer/Consultant** ☐ **Group Contact**

[†]New group kit contains welcome letter, Plan Agreement, Summary Plan Description and identification cards.