APPLICATION FOR GROUP CONTRACT

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

For Plan Year 2022

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/Mailing Address

City State Zip

Physical Oklahoma Address (if different from the billing/mailing address)

City State Zip

Telephone Number

Type of Business

Federal Tax ID Number SIC Code

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

Step 2 – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Please provide a minimum of two (2) authorized group contacts. A valid email address is required for each contact. Enter the information for each contact that is to receive access through Online Resources.

Contact Type:

- **Billing –** Authorized contact for billing inquiries; should have access to view and pay invoices online
- **Eligibility –** Authorized contact for eligibility and enrollment inquiries; should have access to enrollment online as indicated (view only or modify)

Eligibility Access:

- **View only –** Contact should have read-only access to online eligibility
- **Modify** – Contact should have ability to make changes through online eligibility

Subgroup Access: Specify subgroup(s) contact is authorized to access; if contact should have access to all subgroups, please type 'ALL'

Group Executive Title

Contact Type (select one): ☐ Billing ☐ Eligibility

Email Telephone

Eligibility Access (select one): ☐ View only ☐ Modify Subgroup Access

Step 2 continues on next page

Step 2, continued from previous page – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Primary Contact Title

Contact Type (select one): ☐ Billing ☐ Eligibility

Email Telephone

Eligibility Access (select one): ☐ View only ☐ Modify

Subgroup Access

Additional Contact Title

Contact Type (select one): ☐ Billing ☐ Eligibility

Email Telephone

Eligibility Access (select one): ☐ View only ☐ Modify

Subgroup Access

Additional Contact Title

Contact Type (select one): ☐ Billing ☐ Eligibility

Email Telephone

Eligibility Access (select one): ☐ View only ☐ Modify

Subgroup Access

An authorized representative for the Employer must approve access to information on this account for the person(s) named above, and for receipt of the monthly billing from Delta Dental via the above selected option. Further, the authorized representative for the Employer must submit written notification to Delta Dental of Oklahoma if a user's access to Online Resources needs to be terminated or access should be provided to additional persons. A Group Change Form is available on Online Resources and the authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.

Step 3 – PLAN EFFECTIVE DATE: (Month) _______________ 01, 2022

Step 4 – ELIGIBILITY AND ENROLLMENT: A minimum of two (2) enrolled individuals per plan required for participation in FCP plans.

Total Number Employees: ____________________ Total Number Ineligible Employees: ____________________

Total Number Eligible Employees: ____________________

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*

☐ The date determined by the Contractor or Plan Sponsor

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 5 – EMPLOYER CONTRIBUTION

Employer contributes (select one): ☐ None ☐ A portion ☐ All

Step 6 – 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)	$26.00	$52.00
Ages 21 and older (Per Covered Person)	$26.00	$52.00

MONTHLY RATES FOR *PEDIATRIC* PLANS (must be under age 19)	☐ Low Option	☐ High Option
One Covered Person	$26.00	$52.00
Two Covered Persons	$52.00	$104.00
Three or more Covered Persons	$78.00	$156.00

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*	Classes I, II and III Services Only	$75 per Person	n/a
Deductible per Plan Year – *Combined High and Pediatric High*	Classes II and II Services Only	n/a	$50 per Person
Plan Maximum Year Benefit Payment – *for covered persons age 19 and older only*	Classes 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 7 – PAYMENT OPTIONS

Designated Billing Contact(s) will be setup with monthly E-Bill notification emails and online payment access through the Online Resources portal.

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

Financial Institution ______________________ Branch ______________________

Branch Address ______________ City ______________ State ______________ Zip ______________

Branch Telephone ______________________

Account Type (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.

Step 8 – PRODUCER/AGENT INFORMATION

Agency	**Five Digit Agency Number**	**Telephone**
City	State	Zip
Producer/Agent Name	Email Address	
Producer/Agent Assistant Name	Email Address	
Second Servicing Producer/Agent Name	Email Address	

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

Step 9 – ACKNOWLEDGEMENT AND SIGNATURES

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.

Employer's Authorized Signature	Title	Date
Producer/Agent Signature		Date

New Group Kit

All federally compliant plan employer 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 the welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.