



2022
GROUP 26+



DELTA DENTAL OF OKLAHOMA

Checklist for New Groups

2022

When enrolling in a new group, there are several key areas essential in providing a smooth implementation. In order to better serve our clients, we have developed a checklist to aid in the process of enrolling and setting up new groups.

- ☐ Application for Group Contract completed in its entirety and signed by the person authorized to contract for the group and producer (if applicable).
 - ☐ **Step 1:** Plan Effective Date
 - ☐ **Step 2:** Employer Information
 - ☐ **Step 3:** Funding Options
 - ☐ **Step 4:** Eligibility and Enrollment
 - ☐ **Step 5:** Employer Contribution
 - ☐ **Step 6:** Plan Options and Plan Selection
 - ☐ **Step 7:** Options for Access to Online Resources
 - ☐ **Step 8:** Third Party Administrators
 - ☐ **Step 9:** Billing and Payment Options
 - ☐ **Step 10:** Producer/Agent Information
 - ☐ **Step 11:** Acknowledgement and Signatures

Please note: Incomplete or inaccurate applications may cause delays in processing time.

- ☐ Individual enrollment form completed and signed by each employee enrolling in the dental plan; enrollment may also be submitted by electronic file. For more information on acceptable electronic file formats, please contact Sales@DeltaDentalOK.org.

Please mail new group submissions to:

Delta Dental of Oklahoma

Attention: Sales

P.O. Box 54709

Oklahoma City, Oklahoma 73154-1709

or send an email to:

Sales@DeltaDentalOK.org



APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – Group 26+

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 – PLAN EFFECTIVE DATE: (Month) _____ 01, 2022

Step 2 – 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 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? ☐ Yes ☐ No If Yes, reporting timeframe required: _____

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, Delta Dental of Oklahoma's (DDOK) secure benefits administration portal for eligibility maintenance and invoice reporting and payment.

Contact Type:

- **Billing** – Authorized contact for billing inquiries; should have access to view and pay invoices
- **Eligibility** – Authorized contact for eligibility and enrollment inquiries

Primary Group Contact

Title

Email

Telephone

Contact Type: ☐ Billing ☐ Eligibility

☐ Do Not Solicit

Group Executive

Title

Email

Telephone

Contact Type: ☐ Billing ☐ Eligibility

Additional Contact

Title

Email

Telephone

Contact Type: ☐ Billing ☐ Eligibility

Additional contacts can be added if necessary. Please include contact name, title, email, telephone and designate what contact type they should be (billing and/or eligibility) on a separate page and submit with this application.



Step 3 – FUNDING OPTIONS (select one): ☐ Fully Insured ☐ Self-Insured/Administrative Services Only (ASO)

Step 4 – ELIGIBILITY AND ENROLLMENT: A minimum of 10 enrolled or 25% of Eligible Employees, whichever is greater, required for participation in 26+ (only applies to fully insured groups).

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*
- ☐ This 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 _____ % OR \$_____ to employee cost of plan.

Step 6 – 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
- ☐ Delta Dental PPO – Plus Premier “Elite” ☐ Delta Dental PPO – Preventive Plus
- ☐ Delta Dental PPO – Point of Service ☐ Delta Dental PPO – Choice Advantage
- ☐ Delta Dental PPO – Point of Service Advantage

Covered Services and Plan Co-Insurance:

	PPO Network	Premier Network	Out-of-Network
<input type="checkbox"/> Class I – Preventive and Diagnostic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class II – Basic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class III – Major Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> Class IV – Orthodontic Services:	_____ %	_____ %	_____ %
<input type="checkbox"/> N/A <input type="checkbox"/> Dependent Children Only <input type="checkbox"/> Family			

Deductible and Maximum (select one): ☐ Calendar Year ☐ Contract Year

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: _____

Additional Benefit Information, if applicable: _____

Monthly Rates – Fully Insured only (please indicate the appropriate rate structure and rates):

- | | | |
|--|--|---|
| <input type="checkbox"/> Two-tier rate structure | <input type="checkbox"/> Three-tier rate structure | <input type="checkbox"/> Four-tier rate structure |
| Employee Only _____ | Employee Only _____ | Employee Only _____ |
| Family _____ | Employee + One Dependent _____ | Employee + Spouse _____ |
| | Family _____ | Employee + Children _____ |
| | | Family _____ |

Step 7 – 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 will be provided invoice notifications via email.

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 only and/or modify* eligibility in Online Resources.

View Only: Read-only access to online eligibility.

Modify: Ability to make changes through online eligibility.

*Fully insured groups only.

Contact Name	Online Resources User Name if previously assigned	Subgroup(s) Access	Online Eligibility Select One		Email Address (Required)
			View Only	Modify	

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 of Oklahoma 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 8 – THIRD PARTY ADMINISTRATORS

Third party administrators (TPA) listed in this section are authorized contacts for the designated service provided.

EDI/Eligibility _____

COBRA Administrator _____

FSA Administrator _____

Other _____



Step 9 – BILLING AND PAYMENT OPTIONS

Billing Notification (select one): ☐ Online Resources – Detail E-Bill (must complete step 7) ☐ Paper Summary Bill

Payment Options (select one): ☐ Automatic Draft[†] ☐ Online Resources FastPay™ (must complete step 7) ☐ Paper Check

[†]To set up automatic draft for the fifth (5th) day of each month, 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 _____

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 10 – 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 _____

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

Step 11 – 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 _____

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

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



<input type="checkbox"/> DELTA DENTAL PPO - PREVENTIVE PLUS	<input type="checkbox"/> DELTA DENTAL PREMIER
<input type="checkbox"/> DELTA DENTAL PPO	<input type="checkbox"/> DELTA DENTAL PREMIER - CHOICE
<input type="checkbox"/> DELTA DENTAL PPO - PLUS PREMIER	<input type="checkbox"/> DELTA DENTAL PPO - CHOICE
<input type="checkbox"/> DELTA DENTAL PPO - PLUS PREMIER "ELITE"	<input type="checkbox"/> DELTA DENTAL PPO - CHOICE ADVANTAGE
	<input type="checkbox"/> DELTA DENTAL PPO - POINT OF SERVICE

GROUP#/SUBGROUP#	LOCATION CODE
<div style="display: flex; justify-content: space-around;"> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div></div> </div>	<div style="display: flex; justify-content: space-around;"> <div><div></div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div><div></div></div> </div>

Subscriber Information: <i>(please complete in ink for enrollment/eligibility updates)</i>																						
SUBSCRIBER NAME (LAST)										(FIRST)					(M.I.)		SUFFIX		SEX		MARITAL STATUS	
																			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> S	
SUBSCRIBER SOCIAL SECURITY NUMBER						BIRTH DATE				FULL-TIME HIRE DATE				COVERAGE EFFECTIVE DATE						STATUS		
<div> <div></div><div></div><div></div> </div> <div> <div></div><div></div> </div> <div> <div></div><div></div><div></div><div></div> </div>						<div> <div></div><div></div> </div> <div> <div></div><div></div> </div>				<div> <div></div><div></div><div></div><div></div> </div> <div> <div></div><div></div> </div>				<div> <div></div><div></div><div></div><div></div><div></div><div></div> </div> <div> <div></div><div></div><div></div><div></div> </div>								
ADDRESS																		<input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Dep. <input type="checkbox"/> Other: _____				
CITY												STATE		ZIP		CHECK HERE IF THIS IS A NEW ADDRESS				<input type="checkbox"/>		

Enrollment/Eligibility Update Information:		EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION:	
TYPE OF ENROLLMENT/ELIGIBILITY UPDATE: <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REINSTATEMENT <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> COBRA ELECTION <input type="checkbox"/> TERMINATION OF BENEFITS <input type="checkbox"/> DECLINE <input type="checkbox"/> TERMINATION OF EMPLOYMENT AS OF ____ - ____ - ____		<input type="checkbox"/> CHANGE IN CURRENT ENROLLMENT STATUS FOR: <input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENTS REASON FOR CHANGE: <input type="checkbox"/> DIVORCE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> NAME CHANGE <input type="checkbox"/> LEGAL GUARDIANSHIP <input type="checkbox"/> ADOPTION <input type="checkbox"/> OTHER _____	
GROUP TRANSFER-GROUP#/SUBGROUP# <div style="display: flex; gap: 10px;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> </div>		TO: GROUP#/SUBGROUP# <div style="display: flex; gap: 10px;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> </div>	

Dependent Enrollment/Eligibility Update Information: <i>(please complete for spouse and/or dependent children for enrollment/eligibility update)</i>												
SPOUSE NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]								
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				
DEPENDENT CHILD NAME (LAST)				(FIRST)				(M.I.)	SUFFIX	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
SOCIAL SECURITY NUMBER [][][]-[][]-[][][][]				BIRTH DATE [][]-[][]-[][][][]				<input type="checkbox"/> DISABLED*				

Subscriber's
Signature: _____ Date: _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or updating/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date: The date you were hired with your employer.

Coverage Effective Date: The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Status Definitions (Please select only one status)

Active You are an eligible subscriber.

Retiree You are retired and your employer continues to provide you with dental benefits.

COBRA You are no longer an active subscriber but you have continued coverage under COBRA. Please check with your human resources or personnel department for information regarding COBRA.

Surviving Dep. The surviving spouse or child of a deceased subscriber to whom the employer continues to provide benefits other than under provisions of COBRA.

Enrollment/Eligibility Update Information - This section should only be completed if you are: (1) enrolling yourself or a family member for the first time or (2) if your benefits were terminated and are not being reinstated or (3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your eligible dependents.

Reinstatement: Check for reinstatement coverage for yourself or your eligible dependents.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: Must be completed when you are transferring from one subgroup to another. (All dependents will transfer)

Dependent Enrollment/Eligibility Update Information - This section should be completed when: (1) enrolling dependents or (2) if you are submitting updates/changes to Delta Dental enrollment. (Please include both first and last names of any individuals for whom you are enrolling or submitting an update or change).

* Disabled: Your permanently disabled dependent child. (Requires submission of medical statement)

Delta Dental of Oklahoma Privacy Policy

All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a Privacy Policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental has which may contain your confidential information. Financial companies are able to choose how they share your personal information, however Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

Information We Collect - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, check, credit or debit card payments, insurance claims, and our website. We also collect your personal information from other companies. The types of personal information we collect and share depend on the product or service you have with us. This information can include your name, address, social security number, date of birth, transaction and claim history, medical information, and checking account information.

Utilization Of Information - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business in order to provide our Customers with services and products. These functions include processing your requests, claims and transactions, maintaining your account(s), providing information about new products, responding to court orders and legal investigations, reporting to credit bureaus, and to comply with Federal and State Laws. The information Delta Dental uses to provide a service cannot be restricted by our Customers. However, Delta Dental is able to limit this information on your behalf under HIPAA.

Federal law gives consumers the right to limit information sharing in relation to affiliates' everyday business purposes, information about your creditworthiness, affiliates using your information to market to you, and non-affiliates using your information to market to you. In addition, state laws and other individual companies may give you additional rights to limit sharing.

Delta Dental does not have any affiliates, nor do we share information with non-affiliates for marketing purposes. When you are no longer our Customer, we will continue to share your information as described in this notice.

Our Security - To protect your personal information from unauthorized access and use, we maintain physical, electronic, and procedural safeguards that comply with Federal Law, including computer safeguards and secured files and buildings. We consider nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.

While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers. Therefore, our Customer's confidential information is protected.

If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at 800-522-0188 (Toll Free) or 405-607-2100 (OKC Metro).

Under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

DELTA DENTAL OF OKLAHOMA FEATURES & SERVICES



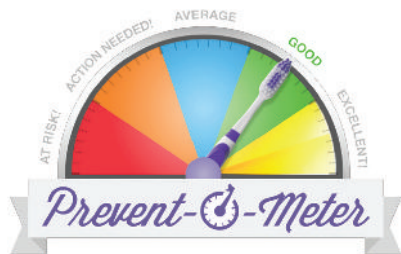
SPOTLIGHT

Delta Dental of Oklahoma provides answers through an online portal known as **SPOTLIGHT**. SPOTLIGHT is online, real-time, 24/7 secure access to benefit information you want—when you want it. Our online services provide:

- Claims Status
- Find a Dentist
- Oral Health Education and more!

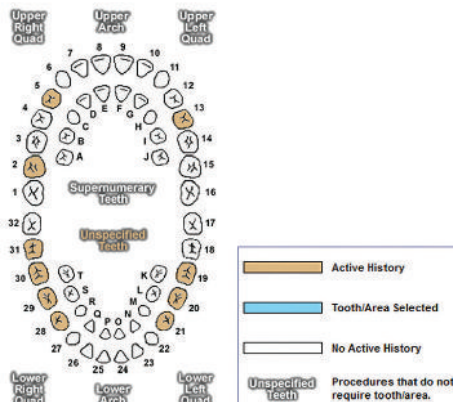
PREVENT-O-METER

A graphical illustration that keeps you up to date on your preventive visits.



MY MOUTH

The My Mouth chart in SPOTLIGHT is a graphic illustration of your teeth, with color codes that show dental work, and an explanation of the procedures performed on each tooth. It is aimed at helping you better understand the dental care you receive.



VIEW MY BENEFITS

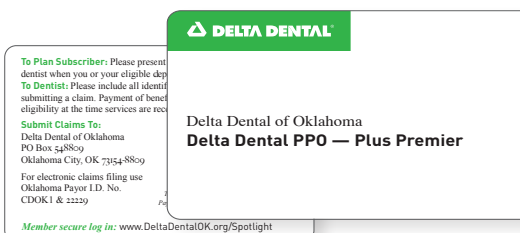
The View My Benefits tool makes it easy to understand your dental benefits. You can see a list of what your dental plan covers and if limitations apply. You can also view your benefits as a PDF to easily print, save, and email.

ACCESS YOUR EXPLANATION OF BENEFITS (EOB)

Your EOB is the key to understanding how Delta Dental of Oklahoma pays your claims. SPOTLIGHT gives you the freedom to access your EOB before you receive it in the mail. You can also view your history for up to seven years.

PRINT YOUR ID CARD

While you don't have to bring your ID card with you when you visit your dentist, sometimes having it brings peace of mind that your claims will be paid appropriately. With SPOTLIGHT, you have 24/7 access to view, print, save or email your ID card directly from your computer. To register for SPOTLIGHT, visit: DeltaDentalOK.org/Spotlight.



DELTA DENTAL OF OKLAHOMA FEATURES & SERVICES



MULTIPLE PROVIDER NETWORKS



Delta Dental offers two of the nation's largest dental provider networks. Delta

Dental Premier consists of more than two-thirds of the nation's dentists. Delta Dental PPO consists of nearly 50% of the nation's dentists and typically provides lower out-of-pocket costs.

NO BALANCE BILLING



If you visit a Delta Dental PPO participating dentist, you are not responsible

for any amounts in excess of Delta Dental's PPO maximum allowable amount. Members enrolled in a Delta Dental PPO-Plus Premier plan enjoy no balance-billing with any participating network provider.

CUSTOMER SERVICE



Our Oklahoma-based Customer Service Department is just a phone

call away. Customer Service Representatives are available to answer calls live Monday – Thursday from 7 a.m. – 6 p.m. and Friday from 7 a.m. – 5 p.m. at

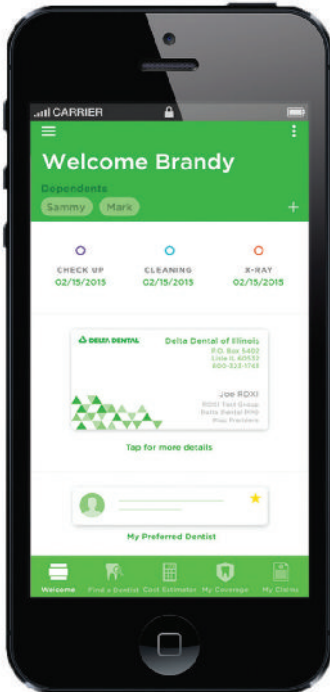
405-607-2100 (OKC Metro) or

800-522-0188 (Toll Free). Oral

health tips, our Find a Dentist tool and many other services are

available to you 24/7 at

DeltaDentalOK.org.



MOBILE APP

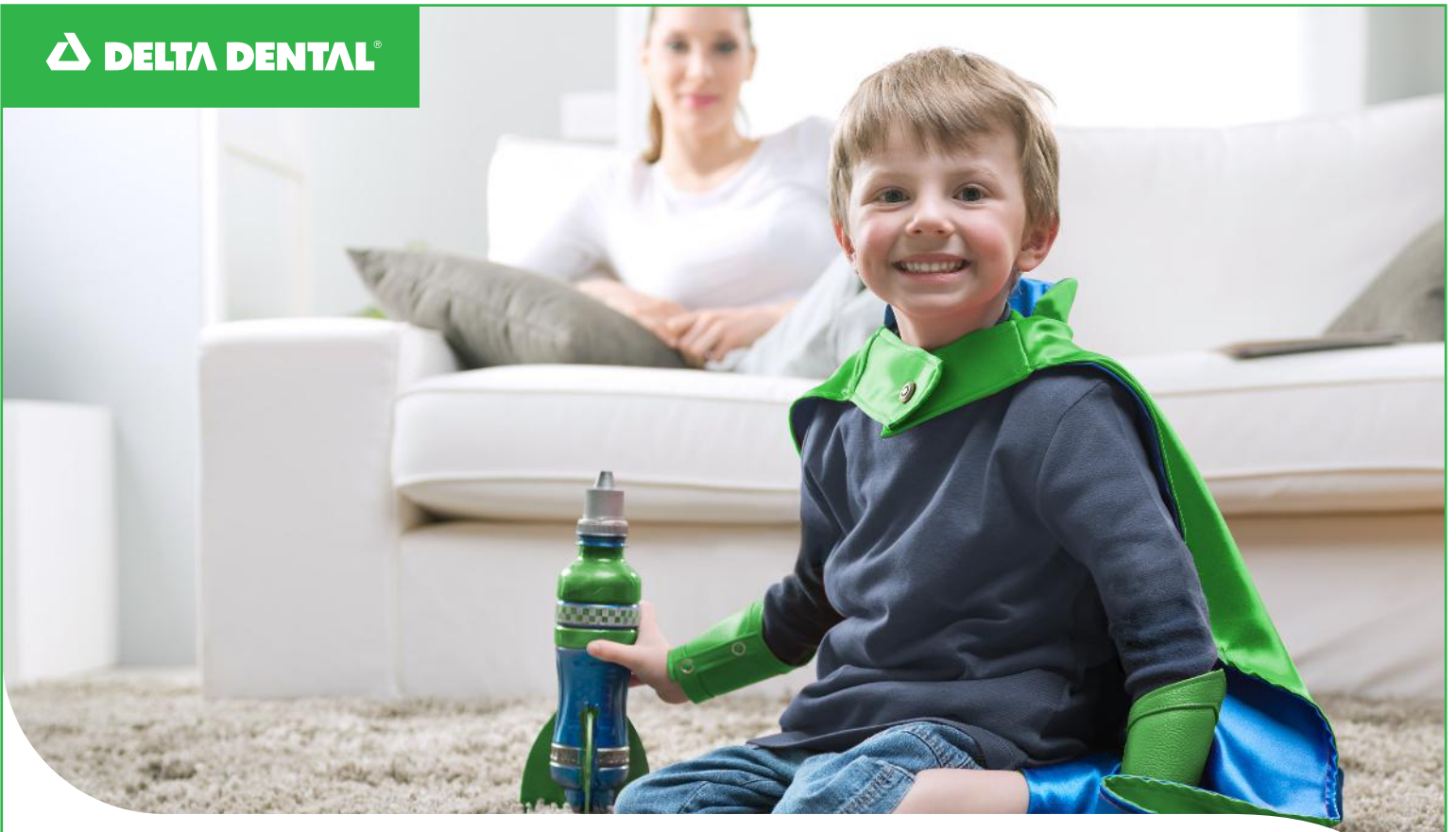
SECURELY ACCESS BENEFITS



With Delta Dental's free mobile app you can stay up-to-date on coverage information, plan type, benefit levels, contact information, deductibles and maximums. You can check the status of your most recent dental claims, view details and even email claim information for both you and your dependents under age 18. In order to securely access this information, be sure to register on the **DeltaDental.com** website and login using your mobile device.

ADDITIONAL TOOLS

- Find a Dentist
- View and email your mobile ID card
- Musical toothbrush timer to help you stay up-to-date with your oral wellness routine



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.*

For more information, visit
DeltaDentalOK.org/HOW

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



[DELTADENTALOK.ORG](https://www.deltadentalok.org)