APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – Group *26+*

For Plan Year 2021

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 billing 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)*
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.

Contact Type:

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

Group Executive Title

Email Telephone Contact Type: ☐ Billing ☐ Eligibility

Primary Group Contact 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.

DELTA DENTAL

Step 2 – PLAN EFFECTIVE DATE: (Month): _____ 01, 2021

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+.

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 _____ % **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 – 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

Covered Services and Plan Co-Insurance:

	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:	_____ %	_____ %	_____ %

☐ N/A ☐ Dependent Children Only ☐ 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):

☐ Two tier rate structure
Employee Only_____
Family_____

☐ Three tier rate structure
Employee Only_____
Employee + One Dependent_____
Family_____

☐ Four tier rate structure
Employee Only_____
Employee + Spouse_____
Employee + Children_____
Family_____

Step 7 – BILLING AND PAYMENT OPTIONS

Billing Notification **(select one)**: ☐ Online Resources – Detail E-Bill **(must complete step 8)** ☐ Paper Summary Bill

Payment Options **(select one)**: ☐ Automatic Draft† ☐ Online Resources FastPay™ **(must complete step 8)** ☐ Paper Check

†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 _____

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 – 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 only and/or modify* eligibility in Online Resources.

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

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 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 9 – 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 10 – 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.