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DELTA DENTAL OF OKLAHOMA

2025

LARGE ACCOUNT

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Checklist for New Groups

2025

When establishing a new group, there are several essential documents necessary for an efficient implementation. To better serve our clients, DDOK has developed a checklist for large account setup and initial enrollment process.

Application for Group Contract

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: Third Party Administrators
(Authorized group signature required)

Step 7: Billing and Payment Options
(Authorized bank 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.*

Initial Enrollment (select one):

- Enrollment Forms completed and signed by each employee
- Completed One-time Load spreadsheet
- Not required for EDI (minimum of 75 subscribers required to use this method)

Send completed application, enrollment documents and other supporting materials to Sales@DeltaDentalOK.org or mail to:

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

APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – Large Account

For Plan Year **2025**

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, 2025

Step 2 – EMPLOYER INFORMATION

Legal Business Name (as it should appear on Summary Plan Description and Plan 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? Yes No If Yes, reporting timeframe required: _____

Please provide a minimum of two (2) authorized group contacts with a valid email address for each. 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. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation – one (1) containing the User ID, 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 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.
- **Executive** – Authorized contact for all aspects of plan administration; should have access to billing and eligibility online.
- **Billing** – Authorized contact for billing inquiries; should have access to view and pay invoices
- **Eligibility** – Authorized contact for eligibility and enrollment inquiries

Eligibility Access:

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

Primary Group Contact				Title		
Email				Telephone		
Contact Type (select one):	Billing	Eligibility	Executive	Eligibility Access (select one):	View only	Modify

Step 2, continued from previous page – EMPLOYER INFORMATION

Secondary Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only Modify

Additional Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only Modify

Additional Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only Modify

Additional Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): ___ View only ___ Modify

Additional Contact Title

Email Telephone

Contact Type (select one): Billing Eligibility Executive Eligibility Access (select one): View only Modify

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. An authorized representative for the Employer approves the individuals/entities listed above 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 above or attached. A 26+ Off-Renewal Plan Change Form is available via Online Resources on the Documents - Forms and Links page. An authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.

Step 3 – 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: ________ *

***Cannot exceed 90 days between first day of full-time employment and coverage start date.**

Employees become ineligible for coverage on (select one): The date of termination The end of month termination occurred

Dependents reaching the age of limitation become ineligible for coverage on (select one):

The date threshold is exceeded

The end of month threshold is exceeded

Is the following included with this application? (select all that apply): Enrollment Forms Electronic Enrollment Data

Domestic Partnership (select one): Eligible Not Eligible

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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*

**Please verify provider participation in the Delta Dental PPO network prior to enrollment at DeltaDentalOK.org/DentistSearch*

Account Structure (select one):

One (1) Subgroup per Plan Option Other (Details attached)

Processing Policy (select one):

DDOK Standard Current Carrier Match* Other*

**Benefit breakdown required*

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(s) and Maximum(s):

Plan Year Deductible(s) and Maximum(s) renew _____ 01 each year.
(month)

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: _____

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 (1) Dependent_____

Family_____

Four-tier rate structure

Employee Only_____

Employee + Spouse_____

Employee + Children_____

Family_____

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Step 6 – THIRD PARTY ADMINISTRATORS

Third party administrators (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.

EDI/Eligibility◊_____

COBRA Administrator◊ _____

Flexible Spending Arrangement (FSA) Administrator_____

Other◊ _____

I authorize 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(s) 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(s) and DDOK. At any time, DDOK reserves the right to request a copy of the signed agreement between the TPA(s) and the Group listed on this application.

Authorized Group Contact Name (please print) Title

Authorized Group Contact Signature Date

Step 7 – BILLING AND PAYMENT OPTIONS

All designated Billing Contacts will receive an electronic monthly invoice via email, as well as automatic draft reminders, if applicable. Billing contacts may remit payment via Automatic Draft or online, by logging into Online Resources to submit payment by credit card, checking or savings account each month.

Payment type (select one): Online Resources – move to step 9
Automatic Draft – 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**.

Billing Notification (select one): Online Resources – Detail E-Bill | Electronic Summary Bill Paper Summary Bill *($15 monthly admin fee))*

Payment Options (select one): Automatic Draft† Online Resources FastPay™ Paper Check

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 – 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.

The Producer/Agency named in this form is authorized to request and approve designated business decisions/changes on behalf of the Group. The Group understands and agrees Delta Dental of Oklahoma (DDOK) shall communicate and transact with the named Producer/Agency, as needed, to complete applicable transactions.

Not Applicable – all decisions and/or changes must be communicated by an authorized group contact.

Limited Authority – authorized to make the following decisions and/or changes on behalf of the employer group:

- Group Name Change
- Group Demographic Change
- Federal Tax Identification Number (TIN) Change
- Minimum Hours Worked
- New Hire Probationary Period
- Member/Dependent Term Rule
- Domestic Partnership Coverage
- Group Contact Change and/or Online Resources Access Updates

Broad Authority – authorized to make Limited Authority decisions/changes, in addition to the following on behalf of the employer group:

- Benefit Year Change
- Contract/Anniversary Year Change
- Employer Contribution Change
- Division/Location Additions/Removals
- Change of Third-Party Administrator(s) (TPA)

Full Authority – authorized to make Broad Authority decisions/changes, in addition to the following on behalf of the employer group:

- Rate Tier Change
- Plan Type Addition/Removal
- Product Conversion
- Alternate Identification (Alt ID) Conversion
- Plan Design Change(s)
- Group Termination Requests
- Group Reinstatement Requests

Step 9 – DOCUMENTS AND FULFILLMENT

New Group Kit

All Large Account 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, Plan Agreement, Summary Plan Description, electronic identification cards and, if applicable, Retiree Conversion materials.

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

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 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 Group Contract. **Warning:** 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 Group Contract, I hereby acknowledge that: All Large Account 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 Large Account group 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

Enrollment/Eligibility Update

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 PREMIER
- ☐ DELTA DENTAL PREMIER – CHOICE
- ☐ 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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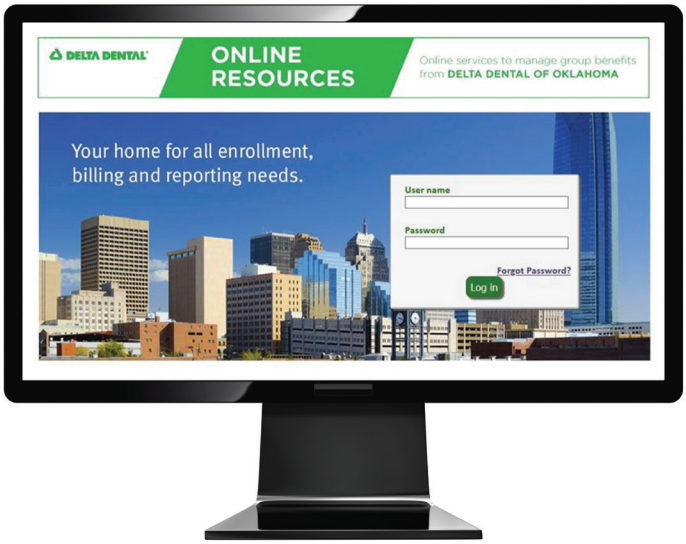
ONLINE RESOURCES



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:

Secure Messaging
Group administrators can contact DDOK securely using the Secure Messaging portal.

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

Online Payments
Fully-insured clients can pay monthly online using a bank account, credit card or by automatic bank draft.

Fully-insured Reporting
Delta Dental's fully-insured clients can access Online Resources to view:

- Aggregate claims
- Covered lives
- Eligibility lookup
- Overage dependent
- Subscriber list
- Detailed monthly invoices with subscriber level breakdown for ease of billing reconciliation

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

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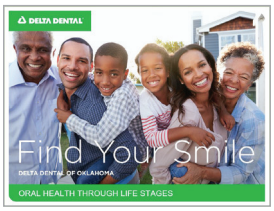
DELTA DENTAL OF OKLAHOMA
ADDITIONAL ACCOUNT SERVICES

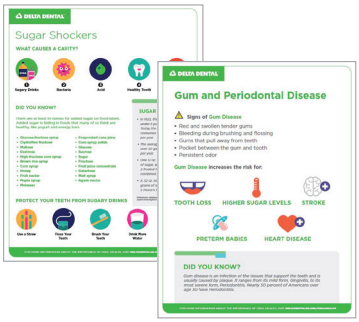


Oral Wellness

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.

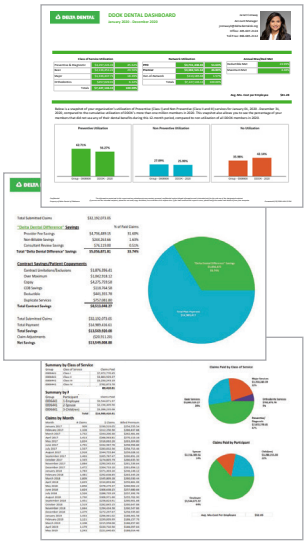
Oral-B Pro 3000 Bundle Giveaway
for groups with 250+ enrollees

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.

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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