For Delta Dental of Oklahoma Use Only:
Program No.

DELTA DENTAL

# APPLICATION FOR EMPLOYER AGREEMENT
## (Delta Dental Patient Direct™ - Select Program)

This Application For Employer Agreement is hereby made a part of the Delta Dental Patient Direct™ Employer Agreement, and is subject to all terms and conditions of the Agreement there of. This Application For Employer Agreement will not be accepted by Delta Dental unless completed in its entirety.

**EMPLOYER NAME** ______________________

**STREET ADDRESS** ______________________
______________________

**MAILING ADDRESS** ______________________
______________________

**TELEPHONE NO.** ( ) ______________________
**FACSIMILE NO.** ( ) ______________________
**WEBSITE ADDRESS** ______________________

**FEDERAL TAX ID NO.** ______________________
**TYPE OF BUSINESS** ______________________
**SIC CODE** ______________________
**ERISA EXEMPT?** ☐ Yes ☐ No

**GROUP EXECUTIVE** ______________________
Title ______________________
Phone No./Fax. No. ______________________
E-Mail Address ______________________

**GROUP CONTACT** ______________________
Phone No./Fax No. ______________________
E-Mail Address ______________________

**BILLING CONTACT** ______________________
Phone No./Fax No. ______________________
E-Mail Address ______________________

**ELIG. CONTACT** ______________________
Phone No./Fax No. ______________________
E-Mail Address ______________________

**PROGRAM EFFECTIVE DATE** ______________________

**ELIGIBILITY/ENROLLMENT:**
To be eligible for enrollment in the Delta Dental Patient Direct™ option of the employer's Delta Dental Select Program, an eligible employee must be at least 18 years of age and a resident of the state of Oklahoma. Enrollment of an employee's eligible dependents is voluntary.

**Total Employees:** __________ Minus Ineligible __________ = Total Eligible Employees __________
Explain Ineligible Employees, e.g., part-time, etc.: ______________________

**Waiting Periods:** New Employees: A new employee's Delta Dental Patient Direct™ program will become effective the first of the month following completion of the employer's new-hire probationary period and enrollment in the Delta Dental Patient Direct™ dental program.

New-Hire Probationary Period ______________________

**EMPLOYEE ENROLLMENT OPTIONS:** Delta Dental Patient Direct™*

* Delta Dental Patient Direct™ is a discount referral dental program, and is not insurance. This dental program is only available to employees (and their dependents) who reside in the state of Oklahoma, and treatment must be provided by properly licensed Oklahoma dentists that are members of the Delta Dental Patient Direct™ program network. Participants pay reduced prices for dental services and procedures included in the program when treatment is provided by providers participating in the Delta Dental Patient Direct™ program network.

**MONTHLY RATES:** _______ Employee Only _______ Employee + Spouse
_______ Employee + Children _______ Employee + Family

**FINANCIAL SUMMARY:** ***Please complete those areas below requiring information.***

**Employer Monthly Contribution to Cost of Dental Program:** Employee Cost_______% or $_______

**(Please complete the reverse side of this Application)**

**PRODUCER/CONSULTANT INFORMATION:** ***Please complete the information requested below.***

Producer/Consultant____________________
Agency____________________
Street Address____________________
____________________
Business Phone No. (   )____________________
E-Mail Address____________________

Social Security No.____________________
Federal Tax ID No.____________________
Mailing Address____________________
____________________
Fax No. (   )____________________
Website Address____________________

## HOLD HARMLESS

Delta Dental has not reviewed the employer's request for a dental program nor designed the Delta Dental Patient Direct™ dental program to meet any federal requirements for Discriminatory Employee Benefit Plans. Said program may not be in compliance with criteria established for Discriminatory Employee Benefit Plans, and employer holds Delta Dental Plan of Oklahoma harmless if said program fails to meet any such requirements.

All information above is true and correct to the best of my knowledge.

____________________
Producer/Consultant’s Signature

____________________
Date

I have reviewed the program and eligibility requirements as stated in this Application for Employer Agreement and accept them.

____________________
Employer's Authorized Signature

____________________
Title

____________________
Date

**Please attach enrollment forms or electronic enrollment data and a check for first month’s program cost. Also, please indicate to whom the new group packet (Employer Agreement, etc.) should be shipped.** ☐**Producer/Consultant** ☐**Group**

***Note: A set of identification cards and a list of covered services will be mailed direct to employees enrolling in the Delta Dental Patient Direct™ program.***