

Group Termination Request Form

DELTA DENTAL OF OKLAHOMA

Group Name: _____

Group Number: _____

Termination Date: _____

Termination requests will be implemented for the requested date, unless insufficient premium payment and/or plan utilization requires the date to be modified. **Please provide the following information so DDOK may process your group termination in a timely manner.**

Reason for Termination (select one):

- | | |
|--|---|
| <input type="checkbox"/> Bundling | <input type="checkbox"/> Moved to Healthcare Exchange Plan |
| <input type="checkbox"/> Business Closure | <input type="checkbox"/> Moved to State of Oklahoma Plan |
| <input type="checkbox"/> Business Headquartered Out of State | <input type="checkbox"/> Underwriting/Claims Processing/Network |
| <input type="checkbox"/> Business Sold | Merger or Acquisition |
| <input type="checkbox"/> DDOK Rates | <input type="checkbox"/> Covered by another carrier |
| <input type="checkbox"/> DDOK Service | <input type="checkbox"/> Covered by another Delta Dental member company |
| <input type="checkbox"/> Dental Benefits Discontinued | <input type="checkbox"/> Covered by DDOK |
| <input type="checkbox"/> Established Self-Funded Plan | |
| <input type="checkbox"/> Moved to DDOK Associated Plan | |

Replacing Dental Benefits Carrier (if applicable): _____

How DDOK could earn your business in the future: _____

_____Would you like a Delta Dental representative to contact you to discuss further? Yes, please contact me No, thank you

Authorized contacts of the organization will retain Online Resources access for 60 days to download final invoice(s) and/or generate necessary reports. If your group termination was completed after billing cutoff, you may not receive a final invoice until the following billing cycle. Delta Dental of Oklahoma's billing schedule is available [here](#).

As an authorized representative for the above listed Group, I hereby authorize termination of my organization's group dental benefits plan(s) for the requested termination date.

Employer's Authorized Name (please print) _____ Title _____

Employer's Authorized Signature _____ Date _____

Submit Completed Forms to ClientRelations@DeltaDentalOK.org for processing.

Termination requests will queue for processing within 30 days of termination, or five (5) business days of receipt if received within the termination month.

Should you have questions or need additional information, please contact your broker or our **Client Relations** team at **405-607-4777** (OKC Metro) or **866-503-4294** (Toll Free) Monday – Thursday 7:00 a.m. – 6:00 p.m. and Friday 7:00 a.m. – 5:00 p.m.