DELTA DENTAL

Select
Change Request Form

DELTA DENTAL OF OKLAHOMA

Group Name: ______________________________

Group Number: ______________________________

Please select the change(s) you would like to make to your plan from the appropriate section(s) below.

An effective date is required for each section containing plan changes.

SECTION 1 – OFF-RENEWAL CHANGE(S) TO BE EFFECTIVE THE FIRST DAY OF ____________________

Change(s) listed in Section 1 may be implemented for any first of the month, prospective effective date without impact to current premium rates. **Select applicable change(s) and complete the corresponding information.**

Group Name Change

____
Legal Business Name (as it should appear on Plan Agreement)

____
Doing Business As (DBA, if applicable):

Group Demographic Change(s)

____
Billing/Mailing Address

____
City State Zip

____
Physical Oklahoma Address *(if billing/mailing is P.O. Box and/or different than physical address)*

____
City State Zip

____
Telephone Number

Federal Tax Identification Number (TIN) Change: ______________________________

Minimum Hours Worked – Full-time employee means an employee who regularly works at least the number of hours in a normal work week set by the Contractor, but not less than ______ hours (not less than 30 hours is DDOK standard contract language).

New Hire Probationary Period – Employees are eligible for coverage on (select one):

- Date of hire
- First of month following date of hire
- The ____ day of continuous, full-time employment*
- First of the month following ____ of continuous full-time employment*

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

Domestic Partnership (select one):

- Eligible
- Not Eligible

Section 1 change(s) will be processed within five (5) business days of receipt and revised plan documents will be provided upon completion.

SECTION 2 – ANNIVERSARY CHANGE(S) WITH UNDERWRITING APPROVAL TO BE EFFECTIVE THE FIRST DAY OF ________________

New anniversary date must remain in effect for 24 months.

Change(s) listed in Section 3 may be implemented for the plan anniversary date, if submitted prior to or within the anniversary month and approved by DDOK Underwriting department. If the requested change(s) impact premium renewal rates, you will receive a Renewal Option Page for review and signature. **Select applicable change(s) and complete the corresponding information.**

Anniversary Date Change – Plan Agreement and premium rates renew on the first day of ________________ each year.

Addition/Removal/Replacement of Plan Type(s) – Please indicate the desired plan(s) to add, remove and/or replace the current plan offering(s). **Enrollment forms are required.** A minimum of two (2) enrolled Eligible Employees is required for participation in Select. At least one (1) must be enrolled in a plan option for that option to be available to the group.

Select Applicable Plan(s) to Add:	☐	☐	☐	☐
Select Applicable Plan(s) to Remove:	☐	☐	☐	☐
Select Applicable Plan(s) to Replace Current Plan:	☐	☐	☐	☐
Plan Options	**Delta Dental PPO – Preventive Plus**	**Delta Dental PPO**	**Delta Dental PPO – Plus Premier**	**Delta Dental PPO – Plus Premier "Elite"**
Preventive/Diagnostic Services	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services	N/A	50%	50%	50%
Orthodontic Services	N/A	50% Child Only	50% Child Only	50% Family
Per Person Deductible	$50	$50	$50	$50
Annual Maximum	$750 Per Person	$1,500 Per Person	$1,500 Per Person	$3,000 Per Person
Lifetime Orthodontic Maximum	N/A	$1,500 Per Child	$1,500 Per Child	$2,000 Per Person
Additional Benefits Available	N/A	N/A	N/A	See Program of Benefits

Section 2 change(s) will be reviewed by Underwriting within five (5) business days. Upon receipt of signed Renewal Option(s) will process within 30 days of your anniversary or five (5) business days of receipt, if received within the renewal month. Revised plan documents will be provided upon completion.

SECTION 3 – ANNIVERSARY CHANGE(S) TO BE EFFECTIVE THE FIRST DAY OF ______________________

Change(s) listed in Section 2 may be implemented for the plan anniversary date without impact to premium renewal rates, if submitted prior to or within the anniversary month.

Select applicable change(s) and complete the corresponding information.

Employer Contribution

Employer contribution to the employee cost of the plan (select one): None A portion All

Alt ID Conversion

Convert from Social Security Number (SSN) to Alternate Identification Number (Alt ID) for all eligible subscribers within a group. Minimum requirements include, but are not limited to: *

Alt ID and the SSN should be included for each subscriber to ensure claims and accumulator history remain intact.

Group is responsible for providing Alt IDs in a format supported by DDOK, Alt IDs:

- Must contain a minimum of six (6), but no more eight (eight) numeric digits
- Have a maximum of 15 characters
- Alpha characters must precede numeric characters (e.g., ABCDEFG12345678)
- Cannot be or contain an SSN
- Must be unique and cannot currently exist in the DDOK system
  - If an Alt ID supplied is currently in use within the DDOK system, the group will b notified and is responsible for providing another Alt ID for the impacted subscriber.
- Alt ID or SSN may be used for any communication between the group and DDOK regarding subscribers and their eligible dependents, including but not limited to the weekly eligibility file, Online Resources and monthly invoicing.
- Alt ID or SSN may be used for any communication between the member, provider and DDOK regarding subscribers and their eligible dependents, including but not limited to eligibility verification, benefit inquiries and claims submission.

**Group authorization and signed Conversion Manual must be submitted 90 days prior to the plan anniversary and/or benefit renewal date.*

Section 3 change(s) will queue for processing within 30 days of your anniversary, or within five (5) business days of receipt, if received within the renewal month. Revised plan documents will be provided upon completion.

Group Name: ______________________________

Group Number: ______________________________

As an authorized representative for the above listed Group, I hereby authorize the selected change(s) to my organization's group dental benefits plan(s) to be implemented for the effective date and/or plan anniversary, as specified in each section. I understand it is the responsibility of the Group to submit written notification to Delta Dental of Oklahoma if account information and/or contact access should be changed or terminated.

____

Authorized Group Contact (please print) Title Date

____

Signature Date

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

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.