

Employer Group Implementation Requirements: 25+ Enrolled Employees

Thank you for choosing Delta Dental of Arizona. Please see the checklist below for the items required for implementation of your new group. All enrollment materials may be emailed to your implementation consultant and must be received by the group's effective date.

Employer Group Enrollment

Please complete the following documents:

- Employer Group Master Application: 25+ Enrolled Employees** (Completed & signed)
- Prior Carrier Coverage** (If applicable)
Please provide a copy of the prior carrier's benefits and a copy of last billing statement.

Billing

Please select one of the following options:

- ACH Form** (Completed & signed)
ACH is available for dental and vision. Invoices will include premiums for both dental and vision, if applicable. First month's premium check is not required for groups using ACH.
- First Month's Premium Check** (Based on enrollment)
Please make check payable to Delta Dental of Arizona and note the premium amounts for dental and vision separately. If group elects to pay by check, please include a copy of first month's premium check with the enrollment materials. However, the group number will not be released until the physical check is received. Original check can be mailed to implementation consultant at the address listed at the bottom of the page.

Employee Enrollment

Please select one of the following options:

- Employee Enrollment Application** (Completed & signed)
Employees enrolling coverage should complete Sections A, B, C, E. Employee and Employer must sign Section E. Employer must complete Section F.
Employees declining coverage should complete sections A, B, D, E. Employee and Employer must sign Section E. Employer must complete Section F.
- Enrollment Spreadsheet**
Spreadsheet must match Delta Dental of Arizona's standard format.
- 834 Enrollment File**
Please contact Delta Dental of Arizona for more information on this option.

Please feel free to contact us with any questions.

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Implementation	Toll-Free	800.352.6132 ext.3979
Consultant	Fax	602.548.5040
	Email	rday@deltadentalaz.com

Employer Group Master App: 25+ Enrolled Employees

SECTION A: General Information				
Company Name				
Address				
City	State	Zip	Email	
Phone		Fax		
Eligibility Contact Name		Eligibility Contact Email		Eligibility Contact Phone
Billing Contact Name		Billing Contact Email		Billing Contact Phone
Type of Industry				SIC Code

SECTION B: Dental Employer Contributions and Participation		
<input type="checkbox"/> Employee only	Total number of eligible employees: _____	Effective Date: ____/____/____ (MM/DD/YYYY)
<input type="checkbox"/> Employee and dependents	Total number waiving with other coverage: _____	
	Total number waiving without other coverage: _____	
	Total number enrolling: _____	
CONTRIBUTIONS		
For Employee: _____%	For Dependents: _____%	Is enrollment tied to a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION C: Vision Employer Contributions and Participation		
<input type="checkbox"/> Employee only	Total number of eligible employees: _____	Effective Date: ____/____/____ (MM/DD/YYYY)
<input type="checkbox"/> Employee and dependents	Total number waiving with other coverage: _____	
	Total number waiving without other coverage: _____	
	Total number enrolling: _____	
CONTRIBUTIONS		
For Employee: _____%	For Dependents: _____%	

SECTION D: Eligibility	
Dependent child(ren) to age: _____	Student status up to age: _____
Humanitarian endeavors included for dependents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic partner coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION E: Current Dental Plan Information (Please attach a copy of the most recent billing statement and benefit summary.)	
Does your company currently have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what type of plan is it? <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> Pre-paid	Effective Date: ____/____/____ (MM/DD/YYYY)
Name of Carrier(s)	Reason for Change

FORM CONTINUES TO NEXT PAGE.

SECTION F: Dental Plan Selection (Selections must match dental quote. Please attach original quote for processing.)

CO-INSURANCE (Enter percentage)

Select your plan	<input type="checkbox"/> PPO	<input type="checkbox"/> PPO plus Premier
Routine Services		%
Basic Services		%
Major Services		%
Orthodontics		%

ADDITIONAL PLAN FEATURES (Check all that apply)

CheckUp Plus™

Orthodontics (Choose one of the options below)

Adult/Child

Child

Calendar Year Deductible:	Benefit Waiting Periods:	Benefit Maximums:
\$ _____ per person	Major _____ months	Calendar Year \$ _____
\$ _____ per family	Orthodontics _____ months	Orthodontics Lifetime \$ _____

Quoted Rates/ASO Fees: Two-tier Three-tier Four-tier Composite

Funding Type: Pooled Risk ASO Other Retention

Run-out Period: _____ months

Run-out Rate: \$ _____

PPO

Employee only	\$ _____
Employee + spouse (employee + one dependent)	\$ _____
Employee + children (employee + two dependents)	\$ _____
Employee + family	\$ _____

PPO plus Premier

Employee only	\$ _____
Employee + spouse (employee + one dependent)	\$ _____
Employee + children (employee + two dependents)	\$ _____
Employee + family	\$ _____

SECTION F.I: Second Dental Plan Selection - if applicable (Selections must match dental quote. Please attach original quote for processing.)

CO-INSURANCE (Enter percentage)

Select your plan	<input type="checkbox"/> PPO	<input type="checkbox"/> PPO plus Premier
Routine Services		%
Basic Services		%
Major Services		%
Orthodontics		%

ADDITIONAL PLAN FEATURES (Check all that apply)

CheckUp Plus™

Orthodontics (Choose one of the options below)

Adult/Child

Child

Calendar Year Deductible:	Benefit Waiting Periods:	Benefit Maximums:
\$ _____ per person	Major _____ months	Calendar Year \$ _____
\$ _____ per family	Orthodontics _____ months	Orthodontics Lifetime \$ _____

Quoted Rates/ASO Fees: Two-tier Three-tier Four-tier Composite

Funding Type: Pooled Risk ASO Other Retention

Run-out Period: _____ months

Run-out Rate: \$ _____

PPO

Employee only	\$ _____
Employee + spouse (employee + one dependent)	\$ _____
Employee + children (employee + two dependents)	\$ _____
Employee + family	\$ _____

PPO plus Premier

Employee only	\$ _____
Employee + spouse (employee + one dependent)	\$ _____
Employee + children (employee + two dependents)	\$ _____
Employee + family	\$ _____

FORM CONTINUES TO NEXT PAGE.

SECTION G: Current Vision Plan Information (Please attach a copy of the most recent billing statement and benefit summary.)

Does your company currently have a vision plan? Yes No

Name of Carrier(s)	Reason for Change
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SECTION H: Vision Plan Selection (Selections must match vision quote. Please attach original quote for processing.)

Plan Number: _____

Quoted Rates: Two-tier Three-tier Four-tier

Employee only	\$ _____
Employee + spouse (employee + one dependent)	\$ _____
Employee + children (employee + two dependents)	\$ _____
Employee + family	\$ _____

SECTION I: Agent/General Agent of Record (If any)

Agent Name _____

Agency Name _____

Address _____

City	State	Zip	Email
Phone	Fax		

_____ Agent Signature _____ AZ Insurance Agent License ID _____ Broker Number _____

General Agent Name _____

General Agency Name _____

_____ General Agent Signature _____ AZ Insurance Agent License ID _____ Broker Number _____

SECTION J: Employer Group Policyholder Acknowledgement

I attest that the above information is correct and agree to provide additional information upon request. The Policy applied for hereby shall be effective upon underwriting approval and the issuance of a group number. The Policyholder and Delta Dental of Arizona (DDAZ) will be legally bound to the provisions of the Policy with the options and alternatives set forth in this Master Application. Any misrepresentation or omission of requested data will cause the Policy, if issued, to be null and void.

Employer Group Name _____

_____ Signature _____ /_____/_____
Date Signed (MM/DD/YYYY)

Signer's Name	Signer's Title
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Email (For future communications regarding this application) _____



SECTION F: Employer Use Only

Employer Name: _____ Group Number: _____
Effective 1st Day Of: ____/____/____ (MM/YYYY) Sub-location: _____

Enrollment Application/Change of Status Form

Instructions on reverse side.

SECTION A: Qualifying Event

NEW HIRE (Complete sections B, C, D, E)
OPEN ENROLLMENT (Complete sections B, C, D, E)
Dental Plan: Premier, PPO plus Premier, PPO, enhanced Premier, Vision
Option: High/Buy-up, Low/Base

CHANGE OF STATUS (Complete sections B, C, D, E)
Dental Vision
Cancel Coverage (Complete section B, E) COBRA (Complete sections B, C, D, E)
Address Change (Complete section B, E)
Name Change To: _____ From: _____
Add/Delete Dependent(s) (Complete sections B, C, E)
Marriage Birth Retire
Divorce Adoption Loss of Coverage Other - Reason: _____

DECLINE COVERAGE (Complete sections B, D, E)
Dental Vision

SECTION B: Employee Information

Social Security Number/EIN Employer Name
Employee's Last Name First MI
Home Address (Mailing)
City State Zip Email
Marital Status Single Married
Gender M F
Date of Birth ____/____/____ (MM/DD/YYYY)

SECTION C: Dependent Information

Table with columns: Add, Change, Delete, Last Name (If different), First, MI, Dental, Vision, Relationship to Employee, Gender M/F, Date of Birth, Full-Time Student Y/N

SECTION D: Other Coverage Information

Do you or any member of your family have coverage under another group dental insurance plan? YES - Please check the appropriate box(es) and complete Section D NO - Please skip to Section E
Insurance Company Name Effective Date of Coverage
Name of Policyholder Policyholder's Date of Birth
Please indicate to whom this coverage applies (Check all that apply). Self Spouse All Children Child(ren)
Name of Dependent Relationship to Policyholder

SECTION E: Authorization

I hereby apply for coverage with Delta Dental of Arizona pursuant to the terms specified on the reverse side of this form, which are hereby incorporated by reference.

Employee's Signature/Authorization Date Signed (MM/DD/YYYY) Employer's Signature/Authorization Date Signed (MM/DD/YYYY)

DDAZ-0002-rev0916

I apply for benefits with Delta Dental of Arizona (Delta Dental), and on behalf of any dependents and myself, I agree to be bound by the provisions of my dental or vision plan (the Plan). If accepted, this application, the identification card and the group contract will constitute the Plan.

I understand and agree that my coverage and that of any dependents will become effective on the date established by my employer in Section F. Any dependents that are added to my Plan later will have different effective dates.

My employer or group administrator is authorized to deduct my share of dental premiums, if any, from my wages for 12 months and during any renewal periods. My employer or group administrator is authorized to remit a premium to Delta Dental and to receive all notices from Delta Dental relating to my coverage. I understand that enrollment is for consecutive 12-month period, and my contribution is subject to change on renewal. Further, I understand that non-compliance with these terms voids any benefits during an enrollment period.

I will notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

I will cooperate with Delta Dental and furnish all information requested to enforce Delta Dental's right to coordinate benefits.

I understand that Delta Dental may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. If false or misleading information is discovered, Delta Dental may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application. Any claims paid during the periods when the coverage was not in force will be deducted from the premium refund. If the benefits paid by Delta Dental exceeds the premium paid, I agree to refund any excess amount to Delta Dental.

Uses and Disclosures of Health Information: At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: 602.938.3131 or 800.352.6132, Email: customerservice@deltadentalaz.com.

Instructions

SECTION A - Determine the Qualifying Event

Please check or complete all boxes that indicate whether you are a new enrollee or you are requesting an update to your current coverage. If you are requesting a coverage update, select the appropriate qualifying event and indicate the date of the event.

New Hire/Open Enrollment: Select the dental plan offered by your employer. If vision is being offered and you would like to apply for coverage, please check the vision box. Please complete Sections B, C, D, and E.

Decline Coverage: If you would like to decline dental or vision coverage, please check the dental and/or vision option. Please complete sections B, D, and E.

Change of Status:

- **Cancel Coverage** - Check the Cancel Coverage box and complete sections B and E.
- **COBRA** - Check the COBRA box and complete sections B, C, D, and E.
- **Address Change** - Check the address change box and complete section B and E.
- **Add/Delete Dependent(s)** - Please indicate the qualifying event add the date of the event. Please complete sections B, C, and E.

SECTION B - Employee Information

Please complete this section in its entirety for all circumstances.

SECTION C - Dependent Information

Check either add, change or delete to select the appropriate dependent action. Complete dependent information and select the dental or vision option to apply for coverage or to make the selected updates.

SECTION D - Other Coverage Information

Complete this section if you or any of your dependents have additional dental coverage that will not be cancelled when this plan becomes effective.

SECTION E - Authorization

Once you have completed the appropriate sections and reviewed the terms above, please sign and date this form.
Employer: Sign and date this form before submitting to Delta Dental of Arizona.

SECTION F - Employer Use Only

Submit the signed form to your employer, who will complete section F.
Employer: Complete section F before submitting to Delta Dental of Arizona.

