

Employer Group Implementation Requirements: 2-24 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 must be received by the group's effective date.

Employer Group Enrollment

Please complete the following documents:

- Employer Group Master Application: 2-24 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.
- Participation Verification**
Please provide one of the following items listed below:
 - Enrollment Application/Change of Status Form or Coverage Waiver Form** (Completed & signed)
 - Quarterly State of Arizona Unemployment Tax and Wage or Payroll Report**
 - Census**

Billing

Please select one of the following options:

- 2-9 Enrolled Employees**
 - ACH Form** (Completed & signed): ACH is required for dental and vision. Invoices will include premiums for both dental and vision, if applicable. The first month's premium check is not required, but may be provided.
- 10-24 Enrolled Employees**
 - ACH Form** (Completed & signed): ACH is available for dental and vision. Invoices will include premiums for both dental and vision, if applicable. The first month's premium check is not required for groups using ACH, but may be provided.
 - Monthly Invoice:** Please make the first month's premium check payable to Delta Dental of Arizona and note the premium amounts for dental and vision separately.

Employee Enrollment

- Employee Enrollment Application/Change of Status Form or Coverage Waiver Form** (Completed & signed)
Employees enrolling in coverage must complete Sections A, B, C, E. Employee and Employer must sign Section E. Employer must also complete Section F.
(Please note that all future enrollments and eligibility updates will need to be submitted through the Employer Connection.)

Please feel free to contact us with any questions.

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Group Master Application: 2-24 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 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 enrolling: _____	
CONTRIBUTIONS		
For Employee: _____%	For Dependents: _____%	

SECTION D: Eligibility	
Dependent child(ren) to age: 26	Students status up to age: 26
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

Option 1: MAC PPO
 Option 2 Lite: MAC PPO
 Option 4 Lite: MAC PPO
 Option 4: MAC PPO
 Option 5 Lite: PPO plus Premier
 Option 5: PPO plus Premier
 Option 6: PPO plus Premier

Routine Services	%
Basic Services	%
Major Services	%
Orthodontics	%

ADDITIONAL PLAN FEATURES (Check all that apply)

CheckUp Plus™
 Composite Fillings
 Orthodontics (Child age 8-19)

Calendar Year Deductible:	Benefit Waiting Periods:	Benefit Maximums:
\$50 per person	Major: 0 months	Calendar Year \$ _____
\$150 per family	Orthodontics: 6 months if no prior coverage	Orthodontics Lifetime \$ _____

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

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

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 (Rate tier for vision must be the same rate tier as dental.)

Plan Name: _____

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

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

This field is for Delta Dental of Arizona only:
Plan Number: _____

FORM CONTINUES TO NEXT PAGE.

Assumption of Responsibility for Electronic Data

This form is required if the group is requesting access to the Employer Connection, Delta Dental of Arizona's secure, online portal for group administration and billing.

Group Information	
Group Name	
Submitted by (Contact Name)	Contact Email Address

Please choose your preferred method for receiving billing statements (select one)	
<input type="checkbox"/> Paper Notification (Only available to groups with 10+ enrolled)	
<input type="checkbox"/> Email Notification (Required for groups with 2-9 enrolled; Optional for groups with 10+ enrolled)	Email Address to Receive Billing Statement
<input type="checkbox"/> Fax Notification (Only available to groups with 10+ enrolled)	Fax Number

Authorized Signature
<p>Delta Dental of Arizona (DDAZ) groups may submit electronic eligibility files instead of paper enrollment forms. Groups may also view billing records online.</p> <p>By signing below, I warrant to DDAZ, that the group indicated above (the Group) is responsible for this data entry. I also certify that I am an authorized representative of the Group and that I have the authority to make eligibility changes. If Group granted online access to an Agent/General Agent of Record on the Employer Group Master Application, I acknowledge that the Agent of Record has the authority to make eligibility changes. I agree that any errors contained in the eligibility files are the responsibility of the Group. Common errors include spelling errors, which may translate into billing adjustments. I understand that there may be an additional cost associated with the changes submitted, even if the change was in error or unintentional. I agree on behalf of the Group to pay for any additional costs associated with my changes. I also agree that the Group is responsible for notifying DDAZ to remove online access for any authorized user, including the Agent/General Agent of Record.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;"> <p>_____</p> <p>Written Signature of Person Submitting</p> </div> <div style="width: 45%;"> <p>_____/_____/_____/_____/_____</p> <p>Date Signed (MM/DD/YYYY)</p> </div> </div> <div style="margin-top: 20px;"> <p>_____</p> <p>Printed Name of Person Submitting</p> </div>



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?
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.