DELTA DENTAL®

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 <u>one</u> 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.

RaSheda Hibbitt
Implementation Consultant

Direct	602.588.3988
Toll-Free	800.352.6132 ext.3988
Fax	602.548.5095
Email	rhibbitt@deltadentalaz.com

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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

☐ Employee only
☐ Employee and dependents

Total number of eligible employees: _____
Total number enrolling: _____

Effective Date: _____/_____/_____ (MM/DD/YYYY)

CONTRIBUTIONS

For Employee: _____% For Dependents: _____% Is enrollment tied to a medical plan? ☐ Yes ☐ No

SECTION C: Vision Employer Contributions and Participation

☐ Employee only
☐ Employee and dependents

Total number of eligible employees: _____
Total number enrolling: _____

Effective Date: _____/_____/_____ (MM/DD/YYYY)

CONTRIBUTIONS

For Employee: _____% For Dependents: _____%

SECTION D: Eligibility

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

Domestic partner coverage? ☐ Yes ☐ 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? ☐ Yes ☐ No

If yes, what type of plan is it? ☐ Indemnity ☐ PPO ☐ Pre-paid **Effective Date:** _____/_____/_____ (MM/DD/YYYY)

Name of Carrier(s)	Reason for Change

FORM CONTINUES TO NEXT PAGE.

Delta Dental of Arizona | 5656 W. Talavi Blvd. Glendale, AZ 85306 | 602.938.3131 | Toll-free: 800.352.6132 | deltadentalaz.com

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

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.

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 (Please print)	
Signature	_____/_____/_____ Date Signed (MM/DD/YYYY)
Signer's Name (Please print)	Signer's Title (Please print)
Email (For future communications regarding this application)	

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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
Option:
☐ High/Buy-up
☐ Low/Base
☐ Vision

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

☐ **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: _____

SECTION B: Employee Information

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

SECTION C: Dependent Information

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
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	
☐	☐	☐		☐	☐			____/____/____ MM DD YYYY	

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
☐ Medical ☐ Dental ☐ COBRA ☐ Retiree ☐ Vision

Insurance Company Name	Effective Date of Coverage _____/_____/_____ (MM/DD/YYYY)
Name of Policyholder	Policyholder's Date of Birth _____/_____/_____ (MM/DD/YYYY)

Please indicate to whom this coverage applies (Check all that apply). ☐ Self ☐ Spouse ☐ All Children ☐ Child(ren) _____ Name(s)

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.

DELTA DENTAL®

Electronic Funds Transfer (EFT) Authorization: Group Dental/Vision Plans

EFT AUTHORIZATION AGREEMENT FOR PREMIUM PAYMENTS

I (we) hereby authorize Delta Dental of Arizona to initiate debit (withdrawal) entries and to initiate, if necessary, credit entries and adjustments for any debit (withdrawal) entries in error to my account and the financial institution indicated below:

Group Information	
Group Name	
Federal Tax ID Number	Group Number
Group Contact Name	Group Contact Phone
Email of Contact to Receive EFT Statement	

Bank Information	
Name of Financial Institution	Account Name (If applicable)
Contact Person (If applicable)	Contact Phone
Bank Routing Number	
Account Number	☐ Savings ☐ Checking

Delta Dental of Arizona will keep all financial information secure and confidential

Authorization	
Name	Name
_____ Authorized Signature _____/_____/_____ Date	_____ Authorized Signature _____/_____/_____ Date

This authorization is to remain in full force and effect until Delta Dental of Arizona, Inc. and said financial institution have received written notification from me of its termination in such time and in such manner to afford Delta Dental of Arizona and said financial institution a reasonable opportunity to act upon it.

I understand that any EFT transactions that are dishonored by my financial institution intended for payment to Delta Dental of Arizona may be assessed a $25 service charge.

Submission
Please email, fax, and or mail the completed application and EFT authorization to:

Delta Dental of Arizona
PO Box 43000
Phoenix, AZ 85080-3000
Email: billing@deltadentalaz.com
Fax: 602.548.5071

DDAZ-0165-rev0517