

Employer Group Implementation Requirements: 10+ 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 specialist and must be received by the group's effective date.

Employer Group Enrollment

Please complete the following documents:

- ☐ **Employer Group Master Application: 10+ Enrolled Employees** (Completed & signed)
- ☐ **Prior Carrier Coverage** (If applicable)

Please provide a copy of the prior carrier's benefits or 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. Billing notifications are emailed to the billing contact on file and invoices can be downloaded from the Benefit Manager Toolkit. If applicable, the group will elect to receive either a consolidated invoice for both dental and vision or separate invoices for dental and vision. This election is to be made on the master application at time of group submission. The first month's premium check is not required.

- ☐ **Check**

Billing notifications are sent to the billing contact on file and invoices can be downloaded from the Benefit Manager Toolkit. If applicable, the group will elect to receive either a consolidated invoice for both dental and vision or separate invoices for dental and vision. This election is to be made on the master application at time of group submission. Check payments should reflect the total due on the invoice and be sent to the remittance address on the invoice. If sending a single check for dental and vision premiums, include the remittance slips for both invoices. The first month's premium check is not required for implementation.

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 must sign Section E. Employer must complete Section F.

Employees declining coverage should complete sections A, B, D, E. Employee 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.

Benefit Manager Toolkit Access

The Benefit Manager Toolkit (BMT) is a secure, online portal for group administration and billing. Each group has a designated BMT administrator who controls additional user access and permissions. The BMT administrator should keep an eye out for an email from donotreply@mydeltadental.com with the subject line "Benefit Manager Toolkit Client Registration." The email will include a link to the registration page and an access code.

(Please note that enrollment and eligibility updates submitted via an 834 enrollment file will override any updates submitted through BMT.)

For onboarding a new client or implementation assistance, please email: implementation@deltadentalaz.com

Please feel free to contact us with any questions.

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Implementation
Specialist

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Employer Group Master App: 10+ Enrolled Employees

Thank you for choosing Delta Dental. This Employer Group Master App may be used to apply for a variety of dental and vision programs offered by Delta Dental. The PPO dental plan and vision plan are underwritten and/or administered by Delta Dental of Arizona (DDAZ). This combined application is being used for your convenience only. Each plan is separately underwritten, administered and serviced.

SECTION A: General Information

Company Name			
Address			
City	County	State	Zip
Email		Business Phone	
TIN		NAICS #	
Type of Industry		SIC Code	

SECTION B: Eligibility and Enrollment

Eligibility Contact Name	Eligibility Contact Email	Eligibility Contact Phone
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Dependent child(ren) to age: _____ Student status up to age: _____
Domestic partner coverage? ☐ Yes ☐ No Waive eligibility period on initial enrollees? ☐ Yes ☐ No

New hire waiting period: <input type="checkbox"/> 1st of the month following _____ <input type="checkbox"/> Date of hire	Qualifying events are effective: <input type="checkbox"/> 1st of the month following event (DDAZ standard) <input type="checkbox"/> Date of event	Member Termination: <input type="checkbox"/> End of month (DDAZ standard) <input type="checkbox"/> Date of termination
How will we receive <u>initial</u> enrollment? <input type="checkbox"/> Enrollment Spreadsheet (Must follow DDAZ standard format) <input type="checkbox"/> Enrollment Forms <input type="checkbox"/> Electronic File Feed	How will we receive <u>ongoing</u> enrollment? <input type="checkbox"/> Benefit Manager Toolkit (portal) <input type="checkbox"/> Enrollment Forms <input type="checkbox"/> Electronic File Feed	Would the group like to receive an overage dependent report? If yes, the report will be available in the Benefit Manager Toolkit. <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION C: Dental/Vision Billing

Is the contact the same as the eligibility contact listed in section B? ☐ Yes ☐ No

Billing Contact Name	Billing Contact Email	Billing Contact Phone
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Monthly payment method: ☐ ACH credit ☐ ACH debit (Required for ASO) ☐ Check Billing notification delivery method: ☒ Email
Do you want consolidated billing for dental and vision, if applicable? ☐ Yes ☐ No Apply consolidated billing to all billing divisions? ☐ Yes ☐ No

SECTION D: Dental/Vision COBRA

Is the contact the same as the eligibility contact listed in section B? ☐ Yes ☐ No

COBRA Contact Name	COBRA Contact Email	COBRA Contact Phone
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COBRA Vendor

How will we receive COBRA enrollment?
☐ Benefit Manager Toolkit (portal) ☐ Electronic File Feed
☐ Enrollment Forms ☐ Excel Spreadsheet (Follow PPO standard file layout.)

FORM CONTINUES TO NEXT PAGE.

SECTION E: Current Dental Plan Information (Please attach a copy of the most recent billing statement or benefit summary.)Does your company currently have a dental plan? ☐ Yes ☐ NoIf yes, what type of plan is it? ☐ Indemnity ☐ PPO ☐ Pre-paid **Effective Date:** ____/____/____ (MM/DD/YYYY)

Name of Carrier(s)

Reason for Change

SECTION F: Current Vision Plan Information (Please attach a copy of the most recent billing statement or benefit summary.)Does your company currently have a vision plan? ☐ Yes ☐ No

Name of Carrier(s)

Reason for Change

SECTION G: Dental Employer Contributions and Participation

Total number of eligible employees: _____

Total number waiving with other coverage: _____

Total number waiving without other coverage: _____

Total number enrolling: _____

Effective Date: ____/____/____
(MM/DD/YYYY)**Contributions:** For Employee: _____% For Dependents: _____%**Contract Term:** ____/____/____ to ____/____/____
(MM/DD/YYYY) (MM/DD/YYYY)**SECTION H: Dental Plan Selection** (Selections must match dental quote. Please attach original quote for processing.)**CO-INSURANCE** (Enter percentage)**Select your plan:** ☐ Delta Dental PPO™ ☐ Delta Dental PPO Plus Premier™

Routine Services	_____ %
Basic Services	_____ %
Major Services	_____ %
Orthodontics	_____ %

ORTHODONTIC COVERAGE (Check one)

- ☐ Yes - Adult/Child
☐ Yes - Child Only
☐ No

Calendar Year Deductible:

\$ _____ per person

Benefit Waiting Periods:

Major _____ months

Benefit Maximums:

Calendar Year \$ _____

\$ _____ per family

Orthodontics _____ months

Orthodontics Lifetime \$ _____

Quoted Rates/ASO Fees: ☐ Two-tier ☐ Three-tier ☐ Four-tier ☐ Composite**Funding Type:** ☐ Pooled ☐ Risk ☐ ASO**RATES**

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

FORM CONTINUES TO NEXT PAGE.

SECTION H.1: 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"/> Delta Dental PPO™	<input type="checkbox"/> Delta Dental PPO Plus Premier™
Routine Services		%
Basic Services		%
Major Services		%
Orthodontics		%

ORTHODONTIC COVERAGE (Check one)

- ☐ Yes - Adult/Child
☐ Yes - Child Only
☐ No

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

RATES

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

SECTION I: Vision Employer Contributions and Participation

Total number of eligible employees: _____ Total number enrolling: _____	Effective Date: ____/____/____ (MM/DD/YYYY)
Contributions: For Employee: _____% For Dependents: _____%	Contract Term: ____/____/____ to ____/____/____ (MM/DD/YYYY) (MM/DD/YYYY)

SECTION J: Vision Plan Selection (Selections must match vision quote. Please attach original quote for processing.)

Plan Number: _____

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

RATES

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

ADDITIONAL PLAN FEATURES

☐ One & Sun™

FORM CONTINUES TO NEXT PAGE.

SECTION K: Benefit Manager Toolkit Access for Dental and Vision Administration**Group Admin Access to Electronic Data**

The Benefit Manager Toolkit (BMT) is Delta Dental of Arizona's secure portal for online enrollment and billing services. Each group must designate a BMT administrator who controls additional user access and permissions.

BMT Admin Name	BMT Admin Title
BMT Admin Email	BMT Admin Phone

Agent Access to Electronic Data

Agent shall/shall not have electronic data access via Delta Dental of Arizona's secure portal. By granting access to Agent, Group is allowing the Agent to potentially make enrollment changes on its behalf. If Agent is granted access, it is the Group's responsibility to notify Delta Dental of Arizona to remove online access.

☐ Accept ☐ Decline

Agent Name	Agent Email
Agent Name	Agent Email
Agent Name	Agent Email

SECTION L: Agent/General Agent of Record

Agent Name			
Agency Name			
Address			
City	State	Zip	Email
Phone		Fax	
Does your agency operate under your Social Security Number or Tax ID Number?			
<input type="checkbox"/> Social Security Number: _____ <input type="checkbox"/> Tax ID Number: _____			

Agent Signature		National Producer Number (Agent)	National Producer Number (Agency)
General Agent Name		General Agency Name	
Does your general agency operate under your Social Security Number or Tax ID Number?			
<input type="checkbox"/> Social Security Number: _____ <input type="checkbox"/> Tax ID Number: _____			

General Agent Signature		National Producer Number (Agent)	National Producer Number (Agency)

FORM CONTINUES TO NEXT PAGE.

SECTION M: Employer Group Authorization to Share Protected Health Information

By signing below, I hereby authorize Delta Dental of Arizona to share, exchange, transmit and receive the Group's member Protected Health Information (PHI) with the following file vendor, agent/broker, and/or third party.

File Vendor Name	
Agent/Broker Name	Other Third Party Name
_____ Signature	_____/_____/_____ Date Signed (MM/DD/YYYY)

SECTION N: 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 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)
Authorized Signer's Name	Authorized Signer's Title
Email (For future communications regarding this application)	



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

EFT AUTHORIZATION AGREEMENT FOR PREMIUM PAYMENTS

I (we) hereby authorize Arizona Dental Insurance Service Inc., dba 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 Number
Email of Contact to Receive EFT Statement	

Bank Information	
Name of Financial Institution	Account Name (If applicable)
Contact Person (If applicable)	Contact Phone Number
Bank Routing Number	
Account Number	<input type="checkbox"/> Savings <input type="checkbox"/> Checking

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

Authorization	
Name	Name
<div>_____</div> <div>Authorized Signature</div>	<div>_____</div> <div>Authorized Signature</div>
<div>____/____/____</div> <div>Date</div>	<div>____/____/____</div> <div>Date</div>

This authorization is to remain in full force and effect until Delta Dental of Arizona 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 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

**SECTION F: Employer Use Only**

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

Enrollment Application/Change of Status Form

Instructions on reverse side.

SECTION A: Qualifying Event

<input type="checkbox"/> NEW HIRE (Complete sections B, C, D, E) <input type="checkbox"/> OPEN ENROLLMENT (Complete sections B, C, D, E) <input type="checkbox"/> Dental Plan: _____ Option: _____ <input type="checkbox"/> Premier <input type="checkbox"/> High/Buy-up <input type="checkbox"/> PPO plus Premier <input type="checkbox"/> Low/Base <input type="checkbox"/> PPO <input type="checkbox"/> enhanced Premier <input type="checkbox"/> Vision	<input type="checkbox"/> CHANGE OF STATUS (Complete sections B, C, D, E) <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Cancel Coverage (Complete section B, E) <input type="checkbox"/> COBRA (Complete sections B, C, D, E) <input type="checkbox"/> Address Change (Complete section B, E) <input type="checkbox"/> Name Change To: _____ From: _____ <input type="checkbox"/> Add/Delete Dependent(s) (Complete sections B, C, E) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Retire <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other - Reason: _____
<input type="checkbox"/> DECLINE COVERAGE (Complete sections B, D, E) <input type="checkbox"/> Dental <input type="checkbox"/> Vision	

SECTION B: Employee Information

Social Security Number	Employer Name			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married Gender <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth ____/____/____ MM DD YYYY
Employee's Last Name	First	MI		
Home Address (Mailing)				
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	Social Security Number	Date of Birth	Full-Time Student Y/N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				____/____/____ MM DD YYYY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				____/____/____ MM DD YYYY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				____/____/____ MM DD YYYY	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>				____/____/____ 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)
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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.