

Delta Dental Insurance Company

Alpharetta, GA 30022
(770) 645-8700

**Small Employer Group
Dental Insurance Application**

Delta Dental's Administrator's Use ONLY
DPO Group #: _____
DeltaCare® USA #: _____

Name of Applicant: _____

Type of Industry: _____ **SIC Code:** _____ **Fed ID/TIN#:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Name of Contact Person: _____ **Telephone No.:** _____

Fax No.: _____ **Email Address:** _____

Billing Address if different: _____ *Contact:* _____

Fax No.: _____ *Email Address:* _____

Program ID #: _____ **Contract Effective Date:** _____ **Length of Contract:** 1 year

Program Type: (Check one):

	Program A	Program B	Program C	Program E		Program Vol
				High	Low	
Diagnostic & Preventive	100%	100%	100%	100%	100%	100%
Basic	80%	80%	100%	80%	50%	80%
Major	50%	50%	50%	50%	50%	50%
Endo/Perio	Basic	Major	Major	Basic	Basic	See below*
Oral Surgery	Basic	Major	Major	Basic	Basic	See below*
Calendar Year Deductible	\$50/\$150	\$50/\$150	\$25/\$75	\$50/\$150	\$75/\$225	\$50/\$150
Deductible waived on D&P?	Yes	Yes	No	Yes	Yes	Yes
Waiting Period **	None	None	None	None	None	12 month
Calendar Year Maximum (Check One)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500			<input type="checkbox"/> \$1,000 High / \$750 Low <input type="checkbox"/> \$1,500 High / \$1,000 Low		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500
50% Child/Student Only Ortho Option (Check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Lifetime Ortho Maximum (Check One)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500***			<input type="checkbox"/> \$1,000 High / \$750 Low <input type="checkbox"/> \$1,500 High / \$1,000 Low***		<input type="checkbox"/> \$1,000 \$350 per yr applied to yrly maximum

*Program Vol: 1 Endo/Perio/Oral Surgery at Major 2 Endo/Perio at Basic, Oral Surgery at Major

**Applies to Major and Ortho, if covered and is waived for all employees with continuous coverage under Applicant's prior dental plan.

Programs A - E: Teeth missing prior to the effective date are covered.
 Program Vol 1 & 2: Teeth missing prior to the effect date are **not** covered unless extracted under the Applicant's prior dental plan, if any, and Section 125 is required.

Fee Basis (Check one): DPO in/DPO out DPO in/MPA out

***Available for employer contributions of 75% or more

Employer Contribution (Check one)	<input type="checkbox"/> 75% – 100%	<input type="checkbox"/> 50% – 74.9%	<input type="checkbox"/> 0% – 49.9%
	Program A-C and Program E	Program A-C and Program E	Program Vol 1 & 2

DPO Rates

Payment Mode: Monthly

Two Tier: EE: \$ _____ EE & family: \$ _____

Three Tier: EE: \$ _____ Two Party: \$ _____ Three Party: \$ _____

Four Tier: EE: \$ _____ EE & spouse: \$ _____ EE & child(ren): \$ _____ EE & Family: \$ _____

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. The statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. It is agreed that premium and a current eligibility list will be submitted to Delta Dental's designated Administrator by the twenty-fifth day of the month prior to the coverage month.

Executed this _____ day of _____, 20____ for the Applicant at: _____
City and State

By: _____
(please print – name and title)

Signature: _____

(Continued)

Small Employer Group Dental Insurance Application (Continued)

Applicant's Name: _____

Census: _____ # of Employees
_____ # of Employees Participating in Dental Provider Organization (DPO) Program
_____ # of Employees Participating in DeltaCare USA Program

Minimum for Enrollment: DPO: 5 Primary Enrollees
DeltaCare USA: 2 Primary Enrollee

Takeover: [] Yes [] No Name of previous carrier: _____

Eligibility: # of Months: _____ or # of Days: _____ Hours / week: _____

Employee Effective Date: 1st day of the month following completion of eligibility [] Date of hire []
1st day of month following date of hire [] Day following completion of eligibility []

Who is eligible: All Employees [x] Children to age: 25 Students to age: 25

Dual Choice with a DeltaCare USA Program? [] No [] Yes.

DeltaCare USA Program (check one)

Employer Contribution (Check one):

- [] Plan 13A [] Plan 15B
[] Plan 14B [] Plan 15C

- [] 0% - 49.9%
[] 50% - 74.9%
[] 75% - 100%

DeltaCare USA Rates

[] Two Tier: EE: \$ _____ EE & family: \$ _____
[] Three Tier: EE: \$ _____ Two Party: \$ _____ Three Party: \$ _____
[] Four Tier: EE: \$ _____ EE & spouse: \$ _____ EE & child(ren): \$ _____ EE & Family: \$ _____

Agent/Broker Information

Are you appointed with Delta Dental Insurance Company? [] Yes [] No

Name: _____ Telephone #: _____ Fax #: _____
Company Name: _____ Company is Inc.? [] Yes [] No
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
TIN or SS#: _____ State & State License #: _____ Email address: _____
Agent Signature: _____ Date: _____

General Agent Information

Name: _____ Telephone #: _____ Fax #: _____
Company Name: _____ Company is Inc.? [] Yes [] No
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
TIN or SS#: _____ State & State License #: _____ Email address: _____
GA's Signature: _____ Date: _____

Accepted for Delta Dental Insurance Company
This _____ day of _____, _____
Authorization _____ initials

Anthony S. Barth, President
Delta Dental Insurance Company