



STATE WHERE COMPANY IS HEADQUARTERED
 Pennsylvania Maryland New York
 Delaware District of Columbia West Virginia

SMALL BUSINESS ADVANTAGE GROUP APPLICATION

Office Use Only
Group # _____

CLIENT INFORMATION

Client name			EIN Number		
Contact Person		4-digit SIC Code		Industry Type	
Title		Telephone number		Fax number	
Street address		City & County		State	ZIP code
Billing address (if different)		City & County		State	ZIP code
Will you offer dual choice to your employees (choice of more than one dental program)? <input type="checkbox"/> No <input type="checkbox"/> Yes. Delta Dental is carrier for both programs. <input type="checkbox"/> Yes. Our carriers are Delta Dental and _____			Will this Delta Dental program replace existing dental coverage your client currently has through another dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, name of previous carrier: _____		
Proposed effective date of coverage		Signature of company officer			Date
Name of company officer (PLEASE PRINT)			Title of company officer (PLEASE PRINT)		

DELTAPREMIER OR DELTAPREFERRED OPTION PROGRAM

	DELTAPREMIER				DELTAPREFERRED OPTION					
	Premier 1	Premier 2	Premier 3	Premier 4	DPO 1	DPO 2	DPO 3	DPO 4	DPO V1	DPO V2
Check one:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic & Preventive	100%*	100%*	100%*	100%*	100%**	100%**	100%**	100%**	100%**	100%**
Basic Restorative	50%*	80%*	80%*	80%*	50%**	80%**	80%**	80%**	80%**	80%**
Oral Surgery	50%*	80%*	80%*	80%*	50%**	80%**	80%**	80%**	80%**	80%**
Endodontics	50%*	80%*	80%*	80%*	50%**	80%**	80%**	80%**	80%**	80%**
Periodontics	50%*	80%*	80%*	80%*	50%**	80%**	80%**	80%**	80%**	80%**
Major Restorative	not a benefit	not a benefit	50%*	50%*	not a benefit	not a benefit	50%**	50%**	not a benefit	50%**
Prosthodontics	not a benefit	not a benefit	50%*	50%*	not a benefit	not a benefit	50%**	50%**	not a benefit	50%**
Orthodontics \$1000 Lifetime Maximum	not a benefit	not a benefit	not a benefit	50%*	not a benefit	not a benefit	not a benefit	50%**	not a benefit	not a benefit
Calendar Year Deductible	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family	\$50 Single \$150 Family
Calendar Year Maximum per person	\$1000	\$1500	\$1500	\$1500	\$1000	\$1500	\$1500	\$1500	\$1000	\$1000

Premier 3 and Premier 4 and DPO 3 and DPO 4 (Major Restorative and Prosthodontics) - There is a six-month waiting period on major restorative and prosthodontic services for clients with fewer than 50 employees with no prior coverage.

Premier 4 and DPO 4 (Orthodontics) - Orthodontics is only available for employer sizes of 50 plus employees or employer sizes of 10-49 that have orthodontic coverage with their current carrier.

DPO V1 and V2 (Oral Surgery, Endodontics and Periodontics) - There is a six-month waiting period on all oral surgery, endodontic and periodontic services. Waiting periods will be waived for groups having prior coverage which included these services. **(Major Restorative and Prosthodontics)** - There is a twelve-month waiting period on all major restorative and prosthodontic services. Waiting periods will be waived for groups having prior coverage which included these services.

*The DeltaPremier program makes its payment for both participating and non-participating dentists according to the DeltaPremier Maximum Plan Allowance (DeltaPremier MPA) or fee charged, whichever is less (DeltaPremier Allowed Amount). DeltaPremier participating dentists agree to accept the DeltaPremier Allowed Amount as payment in full. Delta's payment is a percentage of the DeltaPremier Allowed Amount; a subscriber copayment may be required. Deductibles may also apply. Non-participating dentists may balance bill the patient without limit by Delta Dental.

**The DeltaPreferred Option program makes its payments for both participating and non-participating dentists according to the DeltaPreferred Option Maximum Plan Allowances (DPO MPA) or fee charged, whichever is less (DPO Allowed Amount). DeltaPreferred Option participating dentists agree to accept the DeltaPreferred Option Allowed Amount as payment in full. Delta's payment is a percentage of the DPO Allowed Amount; an enrollee copayment may be required. Deductibles may also apply. Dentists who participate in the DeltaPremier network but not the DeltaPreferred Option network may balance bill the patient the difference between the DeltaPremier Allowed Amount and the DPO Allowed Amount. Non-participating dentists may balance bill the patient without limit by Delta Dental.

CENSUS DATA (DeltaPremier and DeltaPreferred Option programs)

This program requires 10 enrollees minimum

Employee Participation	Total number of eligible employees: _____	Employees _____ % *	*Premier & DPO - Minimum 75% employee and 50% dependent participation required. DPO V1 and V2 - Minimum 25% employee participation.
	Total number of enrollees: _____	Dependents _____ % *	
Distribution by dependency status/Premium	Employee Only _____	Employee & 1 Dep. _____	Employee & Family _____
		Number of enrollees	Monthly premium rates
		x _____	= _____
		x _____	= _____
		x _____	= _____
		Total	\$ _____
Percentage of employer contribution toward premium cost:	_____	Premier & DPO - Minimum 50% of the cost of the plan required) DPO V1 and V2 - No contribution percent required	

DELTACARE PROGRAM

Program Design (check one)	Employer Contribution (check one)
<input type="checkbox"/> Plan 13A	<input type="checkbox"/> Voluntary Dependents
<input type="checkbox"/> Plan 15A	<input type="checkbox"/> Totally Voluntary

CENSUS DATA (DeltaCare program)			
Complete the following information if client is applying for DeltaCare (Delta's DHMO administered by Delta's affiliate PMI)			
Total number of eligible employees: _____		Total number of enrollees: _____ <i>(This program requires 5 enrollees minimum)</i>	
Distribution by dependency status/Premium			
	Number of enrollees	x	Monthly premium rates = Total
Employee only	_____	x	_____ = _____
Employee & 1 Dep.	_____	x	_____ = _____
Employee & Family	_____	x	_____ = _____
			Total _____

EMPLOYEE ELIGIBILITY PERIOD (check one):	
<input type="checkbox"/> Standard: First of month, following _____ days of employment (minimum 30 days)	
<input type="checkbox"/> Custom: As mirrors our medical plan:	
<input type="checkbox"/> 1. First of the month following date of hire	
<input type="checkbox"/> 2. Date of hire (client must pay dues for entire month of coverage regardless of date of hire)	

SUBMIT TO YOUR BROKER:	
DeltaPremier and DeltaPreferred Option 1) This completed, signed application 2) Completed Enrollment/Change forms for each eligible employee 3) Quarterly Wage Statement identifying all eligible employees 4) A check for your first month's premium made payable to GetItHealth Premium Account 5) Signed Business Associate Addendum	DeltaCare 1) This completed, signed application 2) Completed Enrollment/Change forms for each enrollee 3) A check for your first month's premium made payable to GetItHealth Premium Account 4) Signed Business Associate Addendum

IT IS AGREED THAT PREMIUM AND A CURRENT ELIGIBILITY LIST WILL BE SUBMITTED TO DELTA'S DESIGNATED ADMINISTRATOR BY THE TWENTY-FIFTH OF THE MONTH PRIOR TO THE COVERAGE MONTH.

The program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental or its licensed affiliate. It is understood and agreed that this application be made a part of such agreement.

Writing Agent's Information			
Writing Agent's name	Telephone number	Fax number	
Company name		Agent e-mail	
Mailing address	City	State	ZIP code
Writing Agent's signature		Date	
(Please furnish one) <input type="checkbox"/> Social Security number:		<input type="checkbox"/> TIN number:	Company is Inc. <input type="checkbox"/> Yes <input type="checkbox"/> No

Office Use Only	
GA Company Name	<input type="checkbox"/> Level One
GA Sales Representative	<input type="checkbox"/> Level Two

Pennsylvania/Maryland: Application is herewith made for a dental service contract from Pennsylvania Dental Service Corporation, t/d/b/a Delta Dental of Pennsylvania (Delta). It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. It is further understood that Delta underwriting criteria for this contract require that 75% of all eligible employees and 50% of all eligible dependents (if such coverage is offered) be enrolled in the DeltaPremier and DeltaPreferred Option programs, and at least five (5) eligible employees in the DeltaCare program. Any variance in this criteria must be approved by Delta prior to acceptance of the program. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to and accepted by Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Subscribers under the contract. Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental service contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

Pursuant to law, please be advised that it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

New York: Application is herewith made for a dental service contract from Delta Dental of New York, Inc. (Delta). It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. It is further understood that Delta underwriting criteria for this contract require that 75% of all eligible employees and 50% of all eligible dependents (if such coverage is offered) be enrolled in the DeltaPremier and DeltaPreferred Option programs and at least five (5) eligible employees in the DeltaCare program. Any variance in this criteria must be approved by Delta prior to acceptance of the program. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to and accepted by Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Subscribers under the contract. Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental service contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

Pursuant to law, please be advised that any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

District of Columbia: Application is herewith made for a dental service contract from Delta Dental Insurance Company (DDIC). It is understood that this Application is offered as an inducement for issuance of a dental service contract by DDIC for Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by an authorized representative of DDIC. It is further understood that Delta underwriting criteria for this contract require that 75% of all eligible employees and 50% of all eligible dependents (if such coverage is offered) be enrolled in the DeltaPremier and DeltaPreferred Option programs, and at least five (5) eligible employees in the DeltaCare program be enrolled. Any variance in this criteria must be approved by Delta prior to acceptance of the program. Applicant understands that, regardless of the effective date above,

unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to and accepted by Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Subscribers under the contract. Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental service contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

Pursuant to law, please be advised that it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Delaware: Application is herewith made for a dental service contract from Delta Dental of Delaware, Inc. (Delta). It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. It is further understood that Delta underwriting criteria for this contract require that 75% of all eligible employees and 50% of all eligible dependents (if such coverage is offered) be enrolled. Any variance in this criteria must be approved by Delta prior to acceptance of the program. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to and accepted by Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Subscribers under the contract. Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental service program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

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West Virginia: Application is herewith made for a dental service contract from Delta Dental Insurance Company (DDIC). It is understood that this Application is offered as an inducement for issuance of a dental service contract by DDIC for Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. It is further understood that Delta underwriting criteria for this contract require that 75% of all eligible employees and 50% of all eligible dependents (if such coverage is offered) be enrolled. Any variance in this criteria must be approved by Delta prior to acceptance of the program. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to and accepted by Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Subscribers under the contract. Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental service contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

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