

State where company is headquartered:

## CLIENT INFORMATION

Delta Dental \_\_\_\_\_

Client name		EIN	
Contact person	Contact email	Industry type	4-digit SIC code
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 currently through another dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, name of current carrier: _____	
Proposed effective date of coverage	Signature of company officer		Date
Name of company officer (Please print)		Title of company officer (Please print)	

Delta Dental PPO plus Premier or Delta Dental PPO <sup>SM</sup> Program												
	Delta Dental PPO plus Premier <sup>1</sup>						Delta Dental PPO <sup>2</sup>					
	PPO plus Premier 1*	PPO plus Premier 2*	PPO plus Premier 3*	PPO plus Premier 4*	PPO plus Premier V1**	PPO plus Premier V2**	PPO 1*	PPO 2*	PPO 3*	PPO 4*	PPO V1**	PPO 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic & Preventive	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Restorative	50%	80%	80%	80%	80%	80%	50%	80%	80%	80%	80%	80%
Oral Surgery	not a benefit	80%	80%	80%	80%	80%	not a benefit	80%	80%	80%	80%	80%
Endodontics	not a benefit	80%	80%	80%	80%	80%	not a benefit	80%	80%	80%	80%	80%
Periodontics	not a benefit	80%	80%	80%	80%	80%	not a benefit	80%	80%	80%	80%	80%
Major Restorative	not a benefit	not a benefit	50%	50%	not a benefit	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	50%	not a benefit	not a benefit	50%	50%	not a benefit	50%
Implants	not a benefit	not a benefit	50%	50%	not a benefit	50%	not a benefit	not a benefit	50%	50%	not a benefit	50%
Orthodontics \$1,000 Lifetime Maximum	not a benefit	not a benefit	not a benefit	50%	not a benefit	not a benefit	not a benefit	not a benefit	not a benefit	50%	not a benefit	not a benefit
Calendar Year Deductible (S = Single, F = Family)	\$25 S \$75 F	\$50 S \$150 F	\$50 S \$150 F	\$50 S \$150 F	\$50 S \$150 F	\$50 S \$150 F	\$25 S \$75 F	\$50 S \$150 F	\$50 S \$150 F	\$50 S \$150 F	\$50 S \$150 F	\$50 S \$150 F
Calendar Year Maximum per person (PPO provider / Premier and Non-Participating providers)	\$1,500 / \$1,000	\$2,000 / \$1,500	\$2,000 / \$1,500	\$2,000 / \$1,500	\$1,500 / \$1,000	\$1,500 / \$1,000	\$1,000	\$1,500	\$1,500	\$1,500	\$1,000	\$1,000

**\*Major Restorative, Prosthodontics, Implants and Orthodontics:** There is a six-month waiting period on services in these categories for groups with fewer than 25 employees and no prior coverage.  
**\*\*Oral Surgery, Endodontic and Periodontic services:** There is a six-month waiting period on all oral surgery, endodontic and periodontic services. Waiting periods will be waived for groups with prior coverage that included these services. **Major Restorative, Prosthodontic and Implant services:** There is a 12-month waiting period on all major restorative, prosthodontic and implant services. Waiting periods will be waived for groups with prior coverage that included these services.

<sup>1</sup> For Delta Dental PPO plus Premier, Delta Dental makes payments for covered services to dentists who participate in the Delta Dental PPO program based on the Delta Dental PPO Maximum Plan Allowance (PPO MPA) or the dentist's charged fee, whichever is less (PPO Allowed Amount). Delta Dental makes payments for covered services to dentists who participate in only the Delta Dental Premier<sup>®</sup> program based on the Delta Dental Premier Maximum Plan Allowance (Premier MPA) or the dentist's charged fee, whichever is less (Premier Allowed Amount). Delta Dental participating dentists agree to accept the applicable Allowed Amount as payment in full. Delta Dental's benefit is a percentage of the applicable Allowed Amount; an enrollee copayment may be required. Deductibles may also apply. The enrollee is responsible for paying the full fee for services provided by non-participating dentists. Delta Dental will reimburse the enrollee for its percentage of the Delta Dental Premier Allowed Amount. Non-participating dentists may balance bill the enrollee without limit by Delta Dental.

<sup>2</sup> The Delta Dental PPO program makes its payments for both participating and non-participating dentists based on the Delta Dental PPO Maximum Plan Allowance (PPO MPA) or the dentist's charged fee, whichever is less (PPO Allowed Amount). Delta Dental PPO participating dentists agree to accept the PPO Allowed Amount as payment in full. Delta Dental's benefit is a percentage of the PPO Allowed Amount; an enrollee copayment may be required. Deductibles may also apply. Dentists who participate in the Delta Dental Premier network but not the Delta Dental PPO network may also charge the patient the difference between Delta Dental's percentage of the PPO Allowed Amount and the Delta Dental Premier Allowed Amount. Non-participating dentists may balance bill the patient without limit by Delta Dental.

**CENSUS DATA (Delta Dental PPO plus Premier and Delta Dental PPO program)**

**Employee Participation** Total number of eligible employees: \_\_\_\_\_ Employees \_\_\_\_\_ % \*  
 Total number of enrollees: \_\_\_\_\_ Dependents \_\_\_\_\_ % \*

\*PPO plus Premier & PPO - Minimum 75% employee and 50% dependent participation required.

PPO plus Premier & PPO V1 and V2 – Minimum enrollment of 25% of eligible employees or 5 enrolled employees, whichever is greater.

Distribution by Dependency Status/Premium	Employee Only	Employee & 1 Dep.	Employee & Family	Number of enrollees	Monthly premium rates	Total
				_____	X _____ =	_____
				_____	X _____ =	_____
				_____	X _____ =	_____
						\$ _____

Percentage of employer contribution toward employee premium cost: \_\_\_\_\_

Percentage of employer contribution toward dependent premium cost: \_\_\_\_\_

PPO plus Premier and PPO – Minimum 50% of the cost of the plan required

PPO plus Premier V1 and V2 and PPO V1 and V2 – No contribution percent required

**DELTACARE® USA PROGRAM (Delta Dental’s pre-paid dental plan) Underwritten by Alpha Dental Programs, Inc.**

**Program Design (check one)**

**Employer Contribution (check one)**

- Plan 13A
- Plan 15A
- Plan M73 (not available in NY state)

- Employer Contribution
- Voluntary – No Employer Contribution

**CENSUS DATA (DeltaCare USA program)**

Complete the following information if client is applying for DeltaCare USA

Total number of eligible employees: \_\_\_\_\_ Total number of enrollees: \_\_\_\_\_ (This program requires 5 primary enrollees minimum)

Distribution by dependency status/Premium

	Number of enrollees	Monthly premium rates	Total
Employee only	_____ X	_____	= _____
Employee & 1 Dependent	_____ X	_____	= _____
Employee & Family	_____ X	_____	= _____

**EMPLOYEE ELIGIBILITY PERIOD (check one):**

- Standard: First of month, following \_\_\_\_\_ days of employment (minimum 30 days).
- Custom: First of the month following date of hire.

**SUBMIT TO YOUR BROKER:**

Delta Dental PPO plus Premier and Delta Dental PPO

- 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 **GettHealth Premium Account**
- 5) Signed Business Associate Addendum

**SUBMIT TO YOUR BROKER:**

DeltaCare USA

- 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 **GettHealth Premium Account**
- 4) Signed Business Associate Addendum

**IT IS AGREED THAT PREMIUM AND A CURRENT ELIGIBILITY LIST WILL BE SUBMITTED TO DELTA DENTAL’S DESIGNATED ADMINISTRATOR BY THE TWENTH 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. It is understood and agreed that this application be made a part of such agreement.

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

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

Application is herewith made for a dental service contract from:

- |   |  |
|---|--|
| <input type="checkbox"/> Delta Dental of Pennsylvania   | <input type="checkbox"/> Delta Dental of Delaware      |
| <input type="checkbox"/> Delta Dental of New York       | <input type="checkbox"/> Delta Dental of West Virginia |
| <input type="checkbox"/> Delta Dental Insurance Company | <input type="checkbox"/> Alpha Dental Programs, Inc.   |

It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental 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 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 Dental. Any variance in the enrollment criteria must be approved by Delta Dental 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 Dental, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta Dental with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta Dental 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 services contract or as permitted or required by law. Delta Dental 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 Dental.

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. Any person subject to New York law who commits a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.