DELTA DENTAL®

ND New Business Checklist

Please confirm that the following is submitted with all new cases.

- ❑ Completed application for group dental insurance
- ❑ Completed employee enrollment forms or census spreadsheet
- ❑ Online agent-generated proposal from www.directbenefits.com
- ❑ If paying by ACH, please complete the included form and provide a copy of a voided check
- ❑ If paying by check, include a copy of the Binder Check

If applicable, please confirm that all of the following documentation is provided prior to coverage on take-over cases:

- ❑ Copy of Prior Carrier's summary of benefits
- ❑ Copy of Prior Carrier's most recent billing statement

Policy Documents Delivery Acknowledgement

Policy documents will be delivered how requested on the master application. ID cards will be mailed to the employer for distribution.

After all the information listed above is completed and signed, submit all forms using one of the following delivery methods:

Email: agentsupport@directbenefits.com

Fax: **651-649-3502 ATTN: Group Sales**

Mail: **Direct Benefits, Inc.**
55 East 5th Street, Suite 500
Saint Paul, MN 55101

***Please send hard copy of binder check to the address above**

Submission Date:

New groups should be received no later than the 8th of the month of the desired effective date in order to submit to the carrier (*i.e. Feb 1st effective date, please submit to Direct Benefits by Feb 8th)*.

DirectBenefits

DELTA DENTAL

Delta Dental of Minnesota

DirectBenefits

SERVING NORTH DAKOTA

Master Application
Delta Dental Small Business Clients

PART A – Client Information

Legal Company Name _____

Physical Address _____ Phone (____) _____

City _____ State _____ Zip Code _____

Mailing Address ☐ Same as client physical location _____

City _____ State _____ Zip Code _____

Plan Effective Date: _____

Eligibility probationary period for new employees: First of the month following _____ Other _____

Does your company currently have a dental plan? ☐ No ☐ Yes (name of carrier) _____

(Include a copy of most recent billing statement and benefit summary) Prior Plan Start Date: _____

Total Number of Eligible Employees _____

Client Contact Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ Last Name _____

Title _____

Contact Type: ☐ General ☐ Renewal ☐ Mailing ☐ Materials [☐ Overage Dependent]

Telephone: _____ Ext: _____ Cell: _____

Fax: _____ Email Address: _____

☐ Same as Client Physical Location

Mailing Address: _____

City _____ State _____ Postal Code _____

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ Last Name _____

Title _____

Contact Type: ☐ General ☐ Renewal ☐ Mailing ☐ Materials [☐ Overage Dependent]

Telephone: _____ Ext: _____ Cell: _____

Fax: _____ Email Address: _____

☐ Same as Client Physical Location

Mailing Address: _____

City _____ State _____ Postal Code _____

Client – Employer Services Portal Registration

With the Employer Services Portal, you can enroll a new member, update existing members, view eligibility and dental benefits. In addition, **your monthly invoice and other billing details are provided to you *exclusively* through the Employer Services Portal.**

Select a Client Administrator within your company and complete the information below. This Client Administrator will create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will e-mail the Client Administrator with registration information and additional instructions.

Client Administrator Name:_____ Title:_____

Email:_____ Phone Number: _____

Note: The Client Administrator must be an employee of the client

PART B – Delta Dental PPO Plus Premier™ Dental Program Options (choose only one)

☐ **Delta Dental Solutions 1000 and 1500:** Available for groups with 2 – 100 eligible employees, minimum of 2 employees must enroll – [Annual Open Enrollment]

Deductible

Annual - $50 per person/$150 per family

Annual Plan Maximum Options

Please check (✓) one below:

☐ $1,000 per person per year - Including Orthodontic Coverage

☐ $1,500 per person per year - No Orthodontic Coverage

Orthodontic Coverage - minimum of 2 enrolled employees. Coverage for members ages 8 to 19, coverage at 50%, Lifetime Orthodontic Plan Maximum $1,000, 12 month waiting period applies for new groups without 12 months of previous comprehensive coverage.

Please confirm sold plan rates

Employee _____

Employee + 1 _____

Employee+ Child(ren) _____

Family _____

☐ **Delta Dental Flex:** Available for groups with [5-999] eligible employees, minimum of 5 employees must enroll. [Annual Open Enrollment]

Annual Plan Maximum Options

Please check (✓) one below:

☐ $1,000 per person per year

☐ $1,500 per person per year

Orthodontic Coverage - minimum of 2 enrolled employees. Coverage for dependent children ages 8-18, coverage at 50%, Lifetime Ortho Plan Maximum $1,000, 12 month waiting period applies for new employees and groups without 12 months of previous orthodontic coverage.

☐ Yes, we accept orthodontic coverage

☐ No, we decline orthodontic coverage

Please confirm sold plan rates

Employee _____

Employee + 1 _____

Employee+ Child(ren) _____

Family _____

PART C – Broker of Record - Completion of all fields is required

Broker Name _____ **Agency** _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

Phone _____ **E-mail Address** _____

_____ _____

Broker Signature / Insurance Broker License ID Number **Tax ID Number**

Note: Commissions will be paid to this TIN

BROKER SERVICES PORTAL

With the Broker Services Portal, the Broker of Record can update and view the client's eligibility and access the client's billing details. The Broker/Agency will work with their Agency's Broker Administrator, who will add the appropriate user permissions to the Broker's access.

PART D – Premium Remittance and Submission

The first month's premium payment must be received in order for Delta Dental to pay claims for your members. Please submit your first month's premium with your application.

1. Select Payment Option: ☐ **ACH** ☐ **Check** Make payable to: Delta Dental of Minnesota and mail payments to: Delta Dental of Minnesota, NW 5772, PO Box 1450, Minneapolis, MN 55485-5772
2. Complete the Master Dental Contract Application. Retain a copy for your files.
3. Have each employee complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator.
4. Send the Master Dental Contract Application, completed Enrollment Forms or approved Enrollment spreadsheet, corresponding Dental Proposal, and the first month of premium to:

   Delta Dental of Minnesota
   ATTN: Delta Dental Connect SM
   500 Washington Ave South, Suite 2060
   Minneapolis, MN 55415-1163

5. Completed applications and related materials may also be emailed to: Deltadentalconnect@deltadentalmn.org

For questions call 1-800-906-5250 or DeltaDentalConnect@DeltaDentalMN.org

Client Administrator:
By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the Company (Company as named in Part A above) and agree to provide substantiating evidence when requested.

If Delta Dental accepts this application, Delta Dental will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

SIGNATURE BOX

_____ _____ _____

Signature of Authorized Company Official | Title | Date

_____ _____

Client Administrator/Future Correspondence Contact (please print) | Title

_____ _____ _____

Phone Number | Fax Number | Email Address

DELTA DENTAL

DirectBenefits

Delta Dental PPO plus Premier- Pathfinder Plan

Fully-Insured Groups

Automated Clearinghouse Authorization Agreement

Company Name _____

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the ***Total Amount Due*** according to our Invoice / Statement. Premium will be taken on the first business day of each month

Group Number _____

ACH Effective Date _____

Bank Name _____

Bank Address _____

Bank Account Number _____

Type of Account ☐ Checking ☐ Savings

Bank Account Name _____

Bank Routing Number _____

(between these symbols ⑆ ⑆ on the bottom left of your check)

PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account _____

Print

_____

Signature Today's Date

_____

Title Telephone Number

_____

E:Mail address

Questions? Please call our Billing and A/R Department at: 651-406-5902 or 1-800-906-4702

Please complete this form and fax to us at: 1-877-803-2433.

or,

Please complete this form and mail to:

Delta Dental of Minnesota
ATTN: Billing and Accounts Receivable
P.O. Box 9304
Minneapolis, MN 55440-9304

DELTA DENTAL

Delta Dental of Minnesota

Eligibility Enrollment/Update Form

Client Name	Client/Subclient # -

PART A – PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):

Type of Update:	☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination ☐ Transfer	
Transfer From: Client/Subclient # -	**Transfer To:** Client/Subclient # -	**Change is for:** ☐ Subscriber ☐ Dependent ☐ Spouse/Domestic Partner

PART B – FOR MILLENNIUM CHOICE℠ PRODUCT ONLY	**Select a Plan Option:** ☐ Plan Option I – Delta Dental PPO ☐ Plan Option II – Delta Dental Premier

PART C – SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):

Subscriber Name (Last)	(First)	(Middle initial)	Gender

Social Security Number	Birth Date (Month-Day-Year)	Effective Date (M/D/Y)	Hire Date (M/D/Y)

Street Address	☐ Check here if this is a new address

City	State	Zip Code	Status* ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving

PART D – DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):

Relationship to Employee	Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)	Gender	Date of Birth (M/D/Y)	Social Security Number-requested but not required**	Status*
Spouse/ Domestic Partner					☐ Legal ☐ Surviving
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student

*see reverse side for instructions and explanation of codes

**Social security number only requested for dependents with same date of birth

PART E - SUBSCRIBER AND CLIENT SIGNATURE – Sign and date form as verification of your enrollment

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my Employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Do you or your dependents have other dental coverage? Yes No

_____ _____

Name of Carrier Policy/Identification Number

Employee Signature: _____ **Date:** _____

Client Representative Signature _____ **Date:** _____

For Employer Use Only:

Qualifying Event (see next page for list of qualifying events) _____ *Date of Qualifying Event:* _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your employer continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Plan Enrollment/Update Information - This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are not being reinstated or, 3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Transfers: When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

Enrollment/Corrections To Information - This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/ Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse or domestic partner

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's contract with Delta Dental.

Full Time Student: An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Qualifying Events (for Employer Use Only) -

A – Adoption	L – Loss of Coverage	T - Termination/Reduction of Work Hours
B – Birth	M - Marriage	V – Employee Total Disability
D – Divorce/Legal Separation	O – Open Enrollment	X – Employee Eligible for Medicare
E – Death	S – Dependent No Longer Eligible	

Email: eligibility@mydeltadental.com

Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota and its affiliates, (collectively referred to herein as "Delta Dental of Minnesota") comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Compliance Officer, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-448-3815 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-448-3815 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448-3815 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-448-3815（TTY：711）. (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-448-3815 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-448-3815 (መስማት ለተሳናቸው: 711). (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး

1-800-448-3815 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815 (TTY: 711). (German)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 1-800-448-3815 (رقم 711). (Arabic)
ه الصم والبكم:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815 (ATS : 711). (French)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-3815 (TTY: 711)번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815 (TTY: 711). (Tagalog)

ئاگاداری: ئەگەر بە (Kurdish) تۆ بۆ، بەخۆڕایی، زمان یارمەتی خزمەتگوزاریەکانی، دەکەیت قسە کوردی زمانی بە ئەگەر بکە. بەردەستە پ بە1-800-448-3815 (TTY: 711)

توجه: اگر به فارسی زبان گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس1-800-448-3815 (TTY: 711) (Persian / Farsi)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-448-3815 （TY:711）まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-448-3815 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-448-3815 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-448-3815 (TTY: 711) मा कल गर्नुहोस्। (Nepali)