DELTA DENTAL®

NE 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 *(census is preferred for ease of processing)*
- ❑ 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

Thank you for choosing Delta Dental. Please take a moment to complete this form. This form along with your enrollment data and sold proposal will be used to set up your client with Delta Dental.

If you have any questions regarding this form or any of Delta Dental's programs, please feel free to contact your Delta Dental representative.

Instructions:

1. Complete Client Information Form
2. Have each employee complete an Enrollment Form, or work with your Delta Dental Connect Representative to complete an Enrollment Spreadsheet, or an 834 Electronic setup
3. Send this completed application, completed Enrollment Forms, as well as the completed ACH form, voided check, and the initial remittance (if applicable) to the following address: **[Delta Dental of Nebraska, 500 Washington Avenue South, Suite 2060, Minneapolis MN 55415] [Delta Dental of Nebraska, 1807 N 169th Plaza, Suite B, Omaha, NE 68118]**

CLIENT INFORMATION FORM

Coverage or administration for your group will not start until you receive approval in writing from Delta Dental.

Client ID Number *(for Delta Dentaluse only)*: _____

Client Name: _____

Plan: Nebraska

Client Tax Identification/EIN #: _____

Eligible Employees: _____

Effective Date: _____ Contract Length: ☒ 1 year

Physical Location: _____

City: _____ State: _____ ZIP Code: _____ County: _____

Do you need a plan that complies with the ACA's Essential Health Benefits? Yes ☒ No ☐

If yes, what is the date of your medical planrenewal? _____

☐

CLIENT CONTACT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials ☐ Over-age Dependent

Telephone: (_____) _____ Ext: _____ Cell: (_____) _____

Fax: (_____) _____ Email Address: _____

☐ Same as Client Physical Location

Address: _____

City: _____ State: _____ ZIP Code: _____

OTHER CLIENT CONTACT INFORMATION (if the billing contact is different from above)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name:_____ Last Name: _____

Title:_____

Contact Type: ☐ Billing

Telephone: (_____)_____ Ext:_____ Cell: (_____)_____

Fax: (_____)_____ Email Address: _____

☐ Same as Client Physical Location

Address:_____

City:_____ State:_____ ZIP Code: _____

CLIENT - BENEFIT MANAGER TOOLKIT REGISTRATION

Update your group's eligibility online, real time, using our Web-based tool, Benefit Manager Toolkit (BMT). With BMT you can enroll a new member, update existing members, view eligibility and your benefits, and print dentist directories. In addition, **your monthly invoice and other billing details are provided to you *exclusively* through BMT**.

Select a Client Administrator within your company and complete the information below. This administrator will be able to create and maintain your accounts, enabling immediate access for your BMT users. Delta Dental will send your administrator an email with registration information and additional instructions.

Administrator Name:_____ Title: _____

Email:_____ Phone Number:_____

Note: BMT Administrator must be an employee of the client.

AGENT/AGENCY - BENEFIT MANAGER TOOLKIT AUTHORIZATION

I **authorize** that the assigned Agent/Agency (below) requires access to the benefit manager toolkit as indicated.

Please indicate the type of access for the assigned Agent/Agency.

Type of Access:

☐ UPDATE AND VIEW ELIGIBILITY
☐ VIEW ELIGIBILITY ONLY
☐ BILLING DETAILS

Note: The Agent/Agency is responsible for the registration and creation of their BMT account(s).

Authorized Signature:_____ Date:_____

ADDITIONAL INFORMATION

Prior Carrier? ☐ Yes ☐ No *(if yes, please provide a current copy of invoice and benefit summary from prior carrier)*

Name of Prior Carrier:_____

FOR AGENTS ONLY

Agent Name: _____

Agency Name: _____

Checks to: ☐ Agency ☐ Agent

New agent/agency? ☐ Yes ☒ No If yes, please complete the Agent Appointment Application online
http://www.deltadentalne.org/appointment/#/application/get-started

TIN: _____

NPN#: _____ Insurance Producer License ID #: _____

[Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: (_____) _____ Fax Number: (_____) _____

Cell Phone:(_____) _____ Email Address: _____]

Another Agent? Yes ☐

If yes: NPN#: _____ Agent Name: _____

Commission is paid at 10%

*If commission is split please provide percentages:

Agent_____%_____

Agent_____%_____

Start Date: _____

Contact Agent Name (if different than above): _____

Telephone: (_____) _____ Fax Number: (_____) _____

Cell Phone:(_____) _____ Email Address: _____

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Delta Dental of Nebraska in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Delta Dental. This requirement is a condition to eligibility for receiving compensation under Delta Dental's agency/agent compensation program as described in Delta Dental's Agency/Agent Agreement. Delta Dental will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this form I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Delta Dental related to the client's purchase of a Delta Dental benefit plan.

Agent's Signature: _____ Date: _____

BILLING CONFIGURATION

Bill Type (How would you like to receive your bill?): ☐ Mail ☐ Email Notification Only (Benefit Manager Toolkit)

Payment Method: ☐ Check ☐ ACH (DDNE initiated ACH)

SUBCLIENT INFORMATION

- The account structure is used for reporting and accounting purposes.
- Delta Dental will assign a client number.
- Subclient names/numbers will be assigned unless directed otherwise.
- If you prefer to modify, please note that subclient numbers consist of four digit numeric or alpha characters.

Please review the Dental Account Structure below carefully.

CLIENT NUMBER	SUBCLIENT NUMBER	SUBCLIENT NAME
	0001	
	9272	

BILL CONSOLIDATION

All subclients will be billed [separately] [collectively] unless directed otherwise.

Please indicate below any bill consolidation requirements:

1. _____

2. _____

3. _____

ELIGIBILITY AGE LIMITS FOR DEPENDENT CHILD(REN)

Age dependent child(ren) coverage ends: 26

When does dependent child(ren) coverage end? ☒ End of Month

COB PROCESSING INFORMATION

Payment Option Type: ☒ Standard

Support Internal COB (Spouses with the same employer can cover each other): Yes ☐ No ☒

Support External COB (Spouses with different employers can cover each other): Yes ☒ No ☐

SUBSCRIBER DEFINITION (by subclient, if applicable)

Example: *All full-time employees of the Contractor working at least 30 hours per week.*

NEW EMPLOYEE/MEMBER PROBATION PERIOD (WAITING PERIOD)

Example: *On the first day of the month following 90 days of employment*

☐ 1st of the Month Following_____Days

☐ Hire Date

☐ Employer Determined: _____

TERMINATION LANGUAGE (when should coverage end)

☒ Term at End of Month

DOMESTIC PARTNER COVERAGE

Domestic Partner Covered? Yes ☐ No ☐

EMPLOYEE CONTRIBUTION

*Please confirm the percentage that the **employer** contributes for employees and dependents:*

_____% **Employer** Contribution for Employee

_____% **Employer** Contribution for Dependents

_____Other Contribution

ENROLLMENT

Open Enrollment: ☐ Annual / All (Subscribers & Dependents) ☐ Bi-Annual *(Discover Only)*

If yes, Open Enrollment Dates: _____

Initial Enrollment Format:

- ☐ Enrollment Forms (Less than 100 lives)
- ☐ Delta Dental's one-time load layout (Excel File)
- ☐ EDI – Electronic File Feed (allow at least 8 weeks for setup) Vendor Name:_____

Anticipated Date of Receipt:_____ **Who Will be Sending:**_____

Ongoing Enrollment (used to make adds, changes, and terminations going forward):

- ☐ Enrollment Forms (Less than 100 lives)
- ☐ Online Dental Portal (Benefit Manager Toolkit)
- ☐ EDI – Electronic File Feed

Benefit Dates:

Coverage period for annual deductibles and maximums:

☒ Calendar Year (January through December)

AGREEMENT

The undersigned client hereby adopts and subscribes to the terms and provisions in this form and certifies to the best of his/her knowledge and belief, all the responses are true, correct and complete. I verify that the eligible employees are in fact employed by my company 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 five.

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 the Company executes the contract.

In addition to the commissions and/or fees identified specifically for your plan, the Agency/Agent may qualify for additional compensation payments from Delta Dental related to your purchase of a Delta Dental benefit plan. This additional compensation is not charged to your plan. The Agent/Agency of Record has full authority to act on the client's behalf in all matters concerning the client's dental benefits administration, including but not limited to contractual matters and changes to the client's contract.

Misrepresentation or fraud will cause your contract to be null and void from the start and may be in violation of state law.

Payment of the first month's rate for the proposed Delta Dental program(s) and a copy of the proposal must accompany this form.

Signature of Client's Authorized Official:_____ Date:_____

Printed Name: _____

Title: _____

Signature of Agent or Delta Dental Representative:_____ Date: _____

Amount Received: $_____ Check Number: _____

DELTA DENTAL

Delta Dental of Nebraska

DIRECT DEBIT AUTHORIZATION VIA ACH (Automatic Withdrawals)

Client Name: _____

Client Number: _____

Client Sub-location Number(s): _____

Effective Date: _____

Financial Institution Information:

Bank Name: _____

Bank Address: _____

ABA (Routing) Number: _____

Account Number: _____

Type of Account: _____

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above in accordance with my underlying contract with Delta Dental and Delta Dental's ACH processing policies. I understand that I am responsible for any fees incurred due to the ACH being rejected or returned for any reason by my bank and collection action may be taken.

This authorization will remain in full force and effect until Delta Dental has received written notification from me of its termination in such time as to afford Delta Dental and the Financial Institution a reasonable opportunity to act on it, or until all of my payment obligations under the contract have been satisfied.

Should you have any questions regarding your Direct Debit (ACH) Instructions, please contact the Accounting Department at 1.800.838.8863 or at billing@mydeltadental.com.

Office hours are Monday through Friday, 8 a.m. to 5 p.m. EST.

Authorized Signature: _____ Date: _____

Printed Name: _____ Phone Number _____

DELTA DENTAL

Delta Dental of Nebraska

Eligibility Enrollment/Update

NO FORM IS REQUIRED IF WAIVING DENTAL BENEFITS

Client Name: _____ Client#/Subclient# _____ - _____

EXAMPLE: ABCDEF123456

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 of Benefits ◯ Delta Dental Transfer

Group/Subgroup

From: Client/Subclient# _____ - _____ To: Client/Subclient# _____ - _____ Effective Date of Change ___ - ___ - _____

Change is for: ◯ Subscriber ◯ Spouse ◯ Dependent

Subscriber Information *(please complete for all enrollments/updates:)*

Subscriber Name (Last) _____ (First) _____ (M.I.) ___ Sex ◯ Male ◯ Female Status* ◯ Active ◯ COBRA ◯ Retiree ◯ Surviving

Subscriber Social Security Number ___ - ___ - _____ Birth Date ___ - ___ - _____ Coverage Effective Date ___ - ___ - _____ Hire Date ___ - ___ - _____

Street Address _____ ◯ Check here if this is a new address

City _____ State ___ ZIP Code _____ - _____

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

SPOUSE Name (Last) _____ (First) _____ (M.I.) ___ Sex ◯ Male ◯ Female

Social Security Number SSN IS NOT REQUIRED Birth Date ___ - ___ - _____ Status* ◯ Legal ◯ Surviving

DEPENDENT #1 Name (Last) _____ (First) _____ (M.I.) ___ Sex ◯ Male ◯ Female

Social Security Number ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH Birth Date ___ - ___ - _____ Status* ◯ IRS Dep. ◯ Surviving ◯ Disabled ◯ Sponsored

DEPENDENT #2 Name (Last) _____ (First) _____ (M.I.) ___ Sex ◯ Male ◯ Female

Social Security Number ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH Birth Date ___ - ___ - _____ Status* ◯ IRS Dep. ◯ Surviving ◯ Disabled ◯ Sponsored

DEPENDENT #3 Name (Last) _____ (First) _____ (M.I.) ___ Sex ◯ Male ◯ Female

Social Security Number ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH Birth Date ___ - ___ - _____ Status* ◯ IRS Dep. ◯ Surviving ◯ Disabled ◯ Sponsored

DEPENDENT #4 Name (Last) _____ (First) _____ (M.I.) ___ Sex ◯ Male ◯ Female

Social Security Number ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH Birth Date ___ - ___ - _____ Status* ◯ IRS Dep. ◯ Surviving ◯ Disabled ◯ Sponsored

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she 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 authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature_____ Date _____

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 group 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 group medical benefits coverage. **Please check with your human resources or personnel department.**

Surviving: The surviving spouse 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.

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

Group Transfers: When transferring from one group 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

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

IRS Dependent: An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your 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.

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 group’s contract with Delta Dental.**

Email: eligibility@mydeltadental.com
Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916