DELTA DENTAL®

Delta Dental of Wisconsin

ASO – Group Application

Delta Dental of Wisconsin is unable to accept this document with any changes, cross-outs, white-outs, etc., unless the person signing the application initials all such changes.

In order to honor the requested effective date of coverage, **all materials** must be received by Delta Dental no later than five business days prior to the requested effective date. Delta Dental reserves the right to designate the effective date if materials are not received within this timeframe. **Please print clearly.**

REQUIREMENTS TO ENROLL A GROUP

- ☐ This completed group application form
- ☐ A completed ACH form *(if ACH is not chosen, prefund dollars are required)*
- ☐ A copy of the proposal that outlines the benefit design purchased
- ☐ Completed enrollment forms
  (Enrollment forms may not be required if eligibility reporting method is spreadsheet or electronic; see page 4, question #6)

STEP 1 – GROUP INFORMATION

Total number of eligible employees: _____

Total number of employees enrolling: _____

Requested effective date: _____

Legal business name

DBA *(if different)*

Address | PO Box | PO Box Zip

City | State | Zip

Business phone | Fax

Nature of business | SIC code

Benefit contact name | Title | Email

Is the benefit contact authorized to handle PHI *(Protected Health Information)*? ☐ Yes ☐ No

Billing contact name | Title | Email

Is the billing contact authorized to handle PHI *(Protected Health Information)*? ☐ Yes ☐ No

Employer association, group, or coalition *(if applicable)*

Current health carrier

Previous dental carrier *(if applicable)*

STEP 2 – PLAN DESIGN

Important: This section must be completed by the agent or the employer. All information must be provided. **Please print clearly.**

For questions on this application, contact your agent or call our Sales department at 800-236-3713 or email sales@deltadentalwi.com

Employer Contribution & Administrative Fee

1. Select two-tier, three-tier, or four-tier and fill in employer contribution percentages

	☐ Two-Tier		☐ Three-Tier		
Employer Contribution:	_____ % Employee	_____ % Family	_____ % Employee	_____ % Emp. / Dependent	_____ % Emp. / Two or More Dependents

	☐ Four-Tier			
Employer Contribution:	_____ % Employee	_____ % Emp. / Spouse	_____ % Emp. / Child(ren)	_____ % Emp. / Spouse / Child(ren)

2. Fill in plan administrative fee: _____

Plan Information

Plan-design number: _____

(Note: Plan-design number can be found in the upper left corner of the proposal)

Benefits-accumulation period: ☐ Contract year ☐ Calendar year

Coverage for domestic partners: ☐ Yes ☐ No

Coverage for surgical dental procedures:

- ☐ Medical primary, dental secondary
- ☐ Covered in medical plan only *(please supply handbook)*
- ☐ Covered in dental plan only
- ☐ Covered in dental plan only if excluded by medical

Employee Eligibility

Employees are eligible for coverage on *(select one):*

☐ Date of hire *(no waiting period)* ☐ 1st of the month following the date of hire

☐ 1st of the month following _____ days after date of hire ☐ _____ days of employment after date of hire

Employee conditions for eligibility: ☐ 30 hours minimum average hours worked per week

☐ Other *(specify)* _____

Termination date for employees: ☐ Date of termination ☐ End of month following termination

☐ Other *(specify)* _____

Dependents/students are covered to: ☐ Birthdate ☐ End of month following birthdate ☐ End of year

STEP 3 – AGENT INFORMATION

Agent name | Agency name | T.I.N.

Address | Email

Phone | License No.

If commission is to be paid to someone other than the above, please state:

Name

Consultant's name | T.I.N.

Address | Email

STEP 4 – ACH FINANCING AGREEMENT

Automated clearinghouse (ACH) transfer of funds is a safe, easy, and effective way to ensure proper funding of the group's account. To set up an ACH transfer, please complete the information below. This information is only required for groups paying via ACH.

Contact name | Contact phone

Contact email | Secondary contact email

Depository name | Depository transit/WBA No.

Account name | Account No. ☐ Savings or ☐ Checking

I (we) hereby authorize Delta Dental of Wisconsin, Inc., hereinafter called Company, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account and the financial institution indicated above, herein called Depository, to debit and/or credit the same such account. This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name | Name

Signature | Date | Signature | Date

STEP 5 – EMPLOYER AGREEMENT

The Group agrees and understands that this application will become part of the Third Party Administrative (TPA) agreement executed by an authorized officer of Delta Dental of Wisconsin. The Group agrees to be bound by the terms of the TPA agreement to the extent it does not conflict with this application.

Name | Title

Email

Signature | Date

Is this person authorized to handle PHI *(Protected Health Information)*? ☐ Yes ☐ No

STEP 6 – IMPLEMENTATION CHECKLIST

1. **Would you like Delta Dental to assist with employee meetings?**
   ☐ Yes ☐ No

2. **Do you require billing by subdivision?** *(mark all that apply)*
   ☐ COBRA ☐ N/A
   ☐ Other *(attach list and billing contact information)*

3. **Payment method:** ☐ ACH ☐ Prefund

4. **Billing delivery method:**
   ☐ Email *(specify)* _____
   ☐ Paper ☐ Fax # _____

5. **Employees are required to have an identification number for submitting or transmitting enrollment or other information to Delta Dental. Who should assign that ID number?** *(If Delta Dental assigns the ID number, SSN is required on the enrollment transmission)*
   ☐ Delta Dental
   ☐ Employer

6. **Enrollment transmission:**
   ☐ Included ☐ Electronic file
   ☐ Paper forms ☐ Spreadsheet
   Estimated receipt date _____

7. **Coordination of benefits:**
   ☐ Traditional ☐ Nonduplication of benefits

8. **Will Delta Dental administer run-in claims?** ☐ Yes ☐ No
   (*If yes, please provide a deductible and maximum accumulations report from current administrator, or contact name and phone number for current carrier)*
   Name _____
   Phone _____

9. **If mid-benefit-year change, carry over of current annual maximum?**
   ☐ Yes ☐ No *(all members will have full annual maximum available)*
   (*If yes, please provide a maximum accumulations report)*

10. **If mid-benefit-year change, carry over of current deductibles?**
    ☐ Yes ☐ No *(all members will need to satisfy deductibles)*
    (*If yes, please provide a deductible accumulations report)*

11. **Carry over of current lifetime orthodontic paid benefits?**
    ☐ Yes ☐ No *(establish new ortho maximum)*
    (*If yes, please provide an orthodontics accumulations report)*

12. **If answering yes to questions #9-11, list the date that required reports will be provided:**
    _____

STEP 7 – SUMMARY PLAN DESCRIPTION

Delta Dental can assist in the development of the group's Summary Plan Description, or will review the group's SPD if they have developed their own, however Delta Dental cannot give legal advice.

Choose one of the following two options:

☐ **The group will do its own Summary Plan Description** (*If choosing this option, you may skip the questions below. Please provide Delta Dental with a copy of the SPD.)*

☐ **The group would like Delta Dental to help develop the SPD.** (*If choosing this option, please answer all of the questions below.)*

1. **Plan name**:
   _____
   (Example: ABC Company Group Dental Plan)

2. **Plan sponsor's Employer Identification No. (EIN):**
   _____
   (Federally-assigned tax ID)

3. **Plan number used for 5500 reporting purposes:**
   _____
   (Assigned by employer, eg. 501 - Medical, 502 - Dental, 503 - Vision)

4. **Plan year and fiscal year:**
   _____ _____
   (Plan year) *(Fiscal year)*

5. **Contact Information** *(name, title, and address of person at group that legal papers are sent to):*
   _____
   _____
   _____

   Plan administrator *(name, address, and phone number):*
   _____
   _____
   _____

   Followup contact who will review the completed SPD *(name and email):*
   _____
   (Group)
   _____
   (Agent)
   _____
   (Agent)
   _____
   (Agent)

STEP 8 – SUBMIT APPLICATION

Please submit application with enrollment to your Delta Dental representative or mail to:
Delta Dental of Wisconsin | Attn: IST | 2801 Hoover Rd., PO Box 828 | Stevens Point, WI 54481-0828
Email: sales@deltadentalwi.com | Fax: 715-343-7623