DELTA DENTAL®

Delta Dental of Wisconsin

Adult-Only 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 those 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 NEW EMPLOYER

- ☐ A completed employer application form
- ☐ A check for the first month's premium, and a completed ACH form *(if ACH is selected)*
- ☐ A copy of the sold proposal outlining benefits
- ☐ A copy of a wage-and-tax statement *(applies only to employers with 2-4 enrolled)*
- ☐ Completed enrollment forms *(Enrollment forms may not be required if eligibility reporting method is spreadsheet or electronic)*

STEP 1 – EMPLOYER INFORMATION

INFORMATION IN THIS BOX IS REQUIRED

Total Number of Eligible Employees: _____
(Include completed waivers for those not enrolling)

Total Number of Employees Enrolling: _____

Requested Effective Date: _____

Legal Business Name

DBA *(If different)*

Address PO Box

City State Zip

Phone Fax

Nature of Business SIC code

Previous Dental Carrier

Benefit Contact Name Benefit Contact Title

Benefit Contact Phone Benefit Contact Email

Billing Contact Name Billing Contact Title

Billing Contact Phone Billing Contact Email

Current Health Carrier

Payment Method: ☐ ACH *(See page 4)* ☐ Check *(A check from the group for the first month's premium is required for both payment methods)*

Billing Delivery Method: ☐ Paper ☐ Fax ☐ Email If email, specify email address: _____

STEP 2 - PLAN DESIGN

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

Select your options

Pick your plan	High Plan (2-49 Enrolled)	Low Plan (5-49 Enrolled)	
	☐ I want this plan	☐ I want this plan	
	See any dentist	Delta Dental PPO	Delta Dental Premier or any other dentist
Annual Maximum *(Check one where applicable)*	☐ $1,000 ☐ $1,500† ☐ $2,000†	$1,000	$750
Deductible *(Check one where applicable)*	☐ $25 / $75† ☐ $50 / $150 ☐ $75 / $225†	$25 / $75	$50 / $150
Orthodontic Services* *(Requires a minimum of 10 enrolled employees)*	☐ I want ortho ☐ I don't want ortho	☐ I want ortho ☐ I don't want ortho	
Orthodontic Maximum *(Requires a minimum of 10 enrolled employees)*	☐ $1,000 ☐ $1,500 ☐ $2,000	$1,000	$750

**Orthodontic services are for members under age 19.*
†Not available for employers of two to four enrolled.

EMPLOYER CONTRIBUTION & RATES

	Two-Tier			Four-Tier			
Employer Contribution	_____ % Employee	_____ % Family	OR	_____ % Employee	_____ % Emp. / Spouse	_____ % Emp. / Child(ren)	_____ % Emp. / Spouse / Child(ren)
Rates	$ _____ Employee	$ _____ Family	OR	$ _____ Employee	$ _____ Emp. / Spouse	$ _____ Emp. / Child(ren)	$ _____ Emp. / Spouse / Child(ren)

EMPLOYEE ELIGIBILITY

Employees are eligible for coverage on the (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

STEP 3 – AGENT INFORMATION

Agent Name | Agency Name | Agency Fed. ID No.

Address | Email

Phone | Social Security No.* | ☐ NPN* | ☐ License No. * | ☐ Federally-Facilitated Marketplace User ID*

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

Name

Consultant's Name | Phone

Address | Email

**Required*

STEP 4 – EMPLOYER AGREEMENT

In making this application to Delta Dental of Wisconsin (DDW) for group dental coverage under this program, the Group agrees and understands this application will become part of the Contract executed by an authorized officer of DDW. It is agreed that the coverage requested is subject to the approval of DDW and that no agent or representative has authority to make or modify this application for coverage. The Group hereby certifies that all of the above information is true and correct. The Group understands that coverage will not be effective until questions regarding eligibility for coverage have been satisfactorily resolved. The Group agrees to be bound by the terms of the Contract issued by DDW to the extent it does not conflict with this application. Misrepresentation of submitted data will cause this application and subsequent Contract to be null and void.

Name | Title | Email

Signature | Date

Is the individual signing this application authorized to handle PHI *(Protected Health Information)*? ☐ Yes ☐ No

If no, please state the name of the individual in your organization authorized to handle PHI _____

(Approval of coverage is contingent upon underwriting acceptance)

STEP 5 – ACH FINANCING AGREEMENT *(OPTIONAL)*

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. Note: For fully-insured plans with ACH, a check for the first month's premium is required with the application and this ACH form.

Contact Person | Contact Person's Phone | Contact Person's Fax | Contact Person's 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 6 – 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