

GROUP INFORMATION

Legal Business Name _____ DBA (If different) _____

Address _____ P.O. Box _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Years in business _____

Nature of business _____ SIC code _____

Previous dental carrier _____ How long? _____

Benefit contact name _____ Title _____ E-mail _____

Billing contact name _____ Title _____ E-mail _____

Current health carrier _____

Payment method: ACH (see page 2) Check Note: A check from the group for the first month's premium is required for both payment methods.

Billing delivery method: E-mail Paper Fax If e-mail, specify e-mail address: _____

PLAN DESIGN

Use Instant Quote at
www.deltadentalwi.com
for fast, accurate quotes.

PLAN: Premier Plus PPO Enhanced PPO Savings PPO

ANNUAL MAXIMUM: \$1,000 \$1,500 \$2,000

DEDUCTIBLE: \$25/\$75 \$50/\$150 \$75/\$225

ENDO/PERIO/ORAL SURGERY: Standard (covered under major services) Upgraded (covered under basic services)

ORTHODONTIC MAXIMUM: \$1,000 \$1,500 \$2,000 No orthodontic coverage

WAITING PERIODS: Yes No (groups without previous dental only)

— OR —

MaxiMizer UltraSavings PPO Ortho Yes No Waiting periods (groups without previous dental only) Yes No

— OR —

MaxiMizer 2-4 Premier Plus PPO MaxiMizer 2-4 Advantage PPO Note: 2-4 plan, a company wage and tax statement must accompany the group application

Check this box if the group does **not** wish to include the vision discount plan. (Note: Opting out of the vision plan will **not** affect rates.)

Employer contribution: _____% _____% OR _____% _____% _____% _____%
Employee Family Employee Emp./Spouse Emp./Child(ren) Emp./Spouse/Child(ren)

Rates: _____ OR _____
Employee Family Employee Emp./Spouse Emp./Child(ren) Emp./Spouse/Child(ren)

Total number of eligible employees: _____ (Include completed waivers for those not enrolling) Total number employees enrolling: _____

Requested effective date: _____

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

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

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

TO ENROLL A GROUP

Provide the following to Delta Dental prior to the first of the month the coverage is to be effective:

- An application for group dental coverage completed and signed by the employer.
- Completed enrollment/waiver cards for all full-time employees.
- A check from the group for the first month's premium, and a completed ACH form, if ACH is selected.

AGENT INFORMATION

Agent Name _____ Agency Name _____

Address _____ E-mail _____

Phone _____ License No. _____ Social Security No. _____

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

Name _____ Fed. ID No. _____

Consultant's Name _____ Phone _____

Address _____ E-mail _____

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.

The Group also agrees to be bound by the terms of the Contract issued by DDW for the EyeMed Vision Care Discount Program to the extent it does not conflict with this application.

Name _____ Title _____ E-mail _____

Signature _____ Date _____

Approval of coverage is contingent upon underwriting acceptance.

ACH FINANCING AGREEMENT – OPTIONAL

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

Account Name _____ Account Number _____ 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 _____

Delta Dental of Wisconsin is unable to accept this document with any changes, cross-outs, white-outs, etc. unless the person signing the application or the agent of record initials those changes. Both sides of form must be completed. Approval of coverage is contingent upon underwriting acceptance.