

# Delta Dental of Wisconsin

## Group Application Form

Please use this form only for nonpooled risk and ASO (Administrative Services Only) groups.

For plans to be written under one of Delta Dental's pooled plans (MaxiMizer / Access), please use the group application form contained in the brochure for each product.

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.

### APPLICATION WILL BE CONSIDERED AFTER DELTA DENTAL RECEIVES:

- A completed group application form. Be sure to complete all required sections.
- A deposit check for the first month's premium (or, if choosing ACH, completed ACH form -- details inside)
- A copy of the proposal outlining benefits
- Completed enrollment forms (For employees waiving coverage, enrollment forms must be submitted and must indicate that they are waiving coverage, and the reason for the waiver.) Enrollment forms may not be required if some other eligibility reporting method is arranged in advance.

**Stevens Point Headquarters**  
2801 Hoover Road, P.O. Box 828  
Stevens Point, WI 54481  
800-236-3713 Fax 715-343-7623

**Milwaukee Sales Office**  
1233 North Mayfair Road, Suite 204  
Milwaukee, WI 53226  
888-456-2711 Fax 715-343-7623

**Madison Sales Office**  
725 Heartland Trail, Suite 205  
Madison, WI 53717  
877-577-7449 Fax 608-831-9384



# SECTION 1 Complete this section for all groups

## GROUP INFORMATION

Employer (Group) \_\_\_\_\_

Address \_\_\_\_\_  
Street P.O. Box City State ZIP

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Nature of business \_\_\_\_\_ SIC code \_\_\_\_\_

Contact information

Billing contact \_\_\_\_\_ Title \_\_\_\_\_ E-mail \_\_\_\_\_

Benefit contact \_\_\_\_\_ Title \_\_\_\_\_ E-mail \_\_\_\_\_

Person to receive Dental Benefits Source e-newsletter (Name) \_\_\_\_\_ E-mail \_\_\_\_\_

Employer association, group or coalition (if applicable) \_\_\_\_\_

Are other dental plans offered?  Yes  No If yes, describe: \_\_\_\_\_

Previous dental carrier \_\_\_\_\_ Effective date \_\_\_\_\_

Current health carrier \_\_\_\_\_ Effective date \_\_\_\_\_

Address \_\_\_\_\_

## PLAN DESIGN

Important: This section must be completed by the employer. All information must be provided.

The employer contributes \_\_\_\_\_ % of the single rate and \_\_\_\_\_ % of the family rate.

Total number of eligible employees \_\_\_\_\_ Total number enrolled \_\_\_\_\_ Total number not enrolled \_\_\_\_\_

Are employees given the option of cash or other benefits if the dental plan is waived?  Yes  No

Number of employees outside of Wisconsin \_\_\_\_\_ Waiting period for new employees \_\_\_\_\_

Requested effective date \_\_\_\_\_ Benefits accumulation period  Contract year  Calendar year

Plan design number \_\_\_\_\_ Rates (or admin fee) selected \_\_\_\_\_

*Note: Plan design number can be found in the upper left corner of the proposal page*

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 terms of eligibility:  30 hours minimum average hours worked per week  Other (describe) \_\_\_\_\_

Termination date for employees:  Date of termination  End of month following termination  Other (please specify): \_\_\_\_\_

Dependents/students are covered to:  Birthdate  End of month following birthdate  Other (please specify): \_\_\_\_\_

## 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 \_\_\_\_\_

## IMPLEMENTATION CHECKLIST

- Would you like Delta Dental to assist with employee meetings?
  - Yes
  - No
- Would you like introductory benefit information sheets for employees?
  - Yes
  - No
- Do you require billing by subdivision? (mark all that apply)
  - COBRA
  - Other -- attach list and billing contact information.
- Payment method:
  - ACH (if ACH, complete section below)
  - Check
- Billing delivery method:
  - E-mail - specify e-mail address: \_\_\_\_\_
  - Paper
  - Fax
- How will employees be identified when submitting or transmitting eligibility or other information to Delta Dental?
  - Social Security Number (SSN)
  - Employer-Assigned Employee Identification Number (not SSN)

*Note: If using SSN, for privacy purposes, Delta Dental will assign a unique Employee Identification Number for use on all external printed materials (e.g. explanation of benefits, ID cards). Billing or other information going back to the group will be in the format initially submitted to Delta Dental.*

- Enrollment:
  - Included
  - Electronic
  - Paper forms
  - List
 Estimated receipt date: \_\_\_\_\_

## For self-funded groups only

- Coordination of benefits:
  - Traditional
  - Nonduplication of benefits
- Will Delta Dental administer run-in claims?  Yes  No  
 (If yes, provide a deductible and maximum accumulations report from current administrator, or contact name and phone number for current carrier.)  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Carry-over of current paid benefits against annual maximums?
  - Yes  No (establish new annual maximum)
  - (If yes, provide a maximum accumulations report.)
- Carry-over of current deductible status?
  - Yes  No (establish new deductibles)
  - (If yes, provide a deductible accumulations report.)
- Carry-over of current lifetime orthodontic paid benefits?
  - Yes  No (establish new ortho maximum)
  - (If yes, provide an orthodontics accumulations report.)
- If answering yes to Question 10-12, estimated date that required reports will be available: \_\_\_\_\_

## ACH FINANCING AGREEMENT

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  
 \_\_\_\_\_ Depository Name  
 \_\_\_\_\_ Depository Transit/ABA Number  
 \_\_\_\_\_ Account Name  
 \_\_\_\_\_ Account Number  
 Savings or  Checking?  
 \_\_\_\_\_ Depository Contact Person  
 \_\_\_\_\_ Depository Contact Person's Phone

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  
 \_\_\_\_\_ Signature  
 \_\_\_\_\_ Date  
 \_\_\_\_\_ Name  
 \_\_\_\_\_ Signature  
 \_\_\_\_\_ Date

## SECTION 2

Complete this section only for fully-insured groups.  
For self-insured groups, skip to Section 3.

### EMPLOYER AGREEMENT: FULLY-INSURED GROUP

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: \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Approval of coverage is contingent upon underwriting acceptance.*

## SECTION 3

Complete this section only for self-insured groups.  
See Section 2 for fully-insured groups.

### EMPLOYER AGREEMENT: SELF-INSURED GROUP

The Group agrees and understands that this application will become part of the Third Party Administrative 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: \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SUMMARY PLAN DESCRIPTION

Delta Dental will gladly assist in the development of the group's Summary Plan Description, or suggest any necessary modifications of the group's SPD if they have developed their own. We just need your responses to the questions below.

**1. 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.*

**7. Contact information**

*Name or title, address and phone number of person or position at the group that legal papers are sent to:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Plan administrator:** (Name, address and phone.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact for SPD followup:** (Name, and e-mail address of person who will review the completed SPD.)

Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

**2. Plan name:**

\_\_\_\_\_  
(Example: ABC Company Group Dental Plan)

**3. Plan sponsor's Employer Identification Number (EIN):**

\_\_\_\_\_  
(Federally-assigned tax ID)

**4. Plan number for government reporting purposes:**

\_\_\_\_\_  
(Assigned by employer, eg. 501 - Medical, 502 - Dental, 503 - Vision)

**5. Plan year and fiscal year:**

Plan year \_\_\_\_\_ Fiscal year \_\_\_\_\_

**6. Send copy of SPD to agent?  Yes  No**

*If the group works with an insurance agent, Delta Dental will send a copy of the completed SPD to that agent if the group wishes.*

Agent e-mail: \_\_\_\_\_