DELTA DENTAL®

Delta Dental of Wisconsin

Fully Insured – 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 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
- ☐ 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 3)* ◯ 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

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 & Rates

1. **Select two-tier, three-tier, or four-tier**
2. **Fill in employer contribution percentages**
3. **Fill in rates**

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

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

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 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 terms of 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

Coverage for domestic partners:

- ☐ Yes ☐ No

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

STEP 4 – 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 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

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

Signature | Date

Approval of coverage is contingent upon Underwriting acceptance.

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 ☐ Other *(attach list and billing contact information)* ☐ N/A

3. **Payment method:**

   ☐ ACH *(if ACH, complete Step 4 on Page 3)* ☐ Check

4. **Billing delivery method:**

   ☐ Email *(specify email address)* _____ ☐ 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 of electronic file, paper forms, or spreadsheet _____

STEP 7 – SUBMIT APPLICATION

Please submit application with enrollment to your Delta Dental representative or mail to:

Delta Dental of Wisconsin
Attn: Sales
2801 Hoover Rd., PO Box 828
Stevens Point, WI 54481-0828
Email: sales@deltadentalwi.com
Fax: 715-343-7623