



Group Application for Dental Benefits

(FOR 2 OR MORE EMPLOYEES)

Groups must be approved by Underwriting before coverage begins. Please complete entire application for prompt approval.

APPLICANT INFORMATION

Full Legal Name of proposed Applicant (as it will appear on policy):

Street Address:			P.O. Box:	Phone:
City:	State:	Zip:	Industry Type:	Fax:
Owner/President:	Title:	Email Address:	Phone:	
Plan Administrator:	Title:	Email Address:	Phone:	
Eligibility Contact:	Title:	Email Address:	Phone:	

REQUESTED EFFECTIVE DATE

We request for this plan to become effective on the first day of _____, 20____, provided that all of the following has been completed within 15 days of the effective date:

- The Application has been received and the underwriting documentation has been received and approved by Delta Dental of Idaho, and
- Delta Dental of Idaho has been furnished with the completed/signed enrollment cards for all employees, and
- Premium Payments are due by the 10th of each month. If submitting payment by check, please submit to: LB 271372, Delta Dental of Idaho, PO Box 35145, Seattle WA 98124-5145.

Total number of ALL employees: _____ Total number of ALL eligible employees: _____ Total number of employees enrolled: _____

Medical Carrier:	Renewal Month:	Medical Plan Number:
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PLAN SELECTION

Plan Selected:

<input type="checkbox"/> PPO™ 50 - \$1,000/\$1,000	<input type="checkbox"/> PPO™ 25 - \$1,000/\$1,000	<input type="checkbox"/> PPO™ Triple SELECT	<input type="checkbox"/> Premier® 50 - \$1,000
<input type="checkbox"/> PPO™ 50 - \$1,250/\$1,000	<input type="checkbox"/> PPO™ 25 - \$1,250/\$1,000	<input type="checkbox"/> PPO™ Basic	<input type="checkbox"/> Premier® 50 - \$1,000 + Rollover
<input type="checkbox"/> PPO™ 50 - \$1,250/\$1,000 + Rollover	<input type="checkbox"/> PPO™ 25 - \$1,250/\$1,000 + Rollover	<input type="checkbox"/> PPO™ Preventive	<input type="checkbox"/> Premier® 50 - \$1,250
<input type="checkbox"/> PPO™ 50 - \$1,500/\$1,000	<input type="checkbox"/> PPO™ 25 - \$1,500/\$1,000	<input type="checkbox"/> PPO™ Low/High One Preventive PPO 50 \$1,000	<input type="checkbox"/> Premier® 50 - \$1,500
<input type="checkbox"/> PPO™ 50 - \$1,750/\$1,000	<input type="checkbox"/> PPO™ 25 - \$1,750/\$1,000	<input type="checkbox"/> PPO™ Low/High Two Preventive PPO 50 \$1,750/\$1,000	<input type="checkbox"/> Premier® 50 - \$1,750
<input type="checkbox"/> PPO™ 50 - \$2,000/\$1,000	<input type="checkbox"/> PPO™ 25 - \$2,000/\$1,000	<input type="checkbox"/> Custom Plan (ASC & Experienced Rated Groups Only) _____	

Orthodontic Coverage:

<input type="checkbox"/> PPO™ 50 - \$1,250/\$1,000 child orthodontia, \$1,000 lifetime maximum	<input type="checkbox"/> PPO™ 25 - \$1,500/\$1,000 child orthodontia, \$1,500 lifetime maximum
<input type="checkbox"/> PPO™ 50 - \$1,500/\$1,000 child orthodontia, \$1,500 lifetime maximum	<input type="checkbox"/> PPO™ 25 - \$1,500/\$1,000 adult/child orthodontia, \$2,500 lifetime maximum
<input type="checkbox"/> PPO™ 50 - \$1,500/\$1,000 adult/child orthodontia, \$2,500 lifetime maximum	<input type="checkbox"/> Premier® 50 - \$1,000 child orthodontia, \$1,000 lifetime maximum
<input type="checkbox"/> PPO™ 25 - \$1,250/\$1,000 child orthodontia, \$1,000 lifetime maximum	

Funding Type:

<input type="checkbox"/> Community Pool	* If Administrative Service Contract program: \$ _____ per employee per month, or _____ % of claims paid will be the cost for administration.	Funding of ASC group claims paid will be:
<input type="checkbox"/> School Pool		<input type="checkbox"/> Weekly Payment (company initiated via website)
<input type="checkbox"/> Experience Rated		<input type="checkbox"/> Weekly ACH (Delta Dental of Idaho draft)
<input type="checkbox"/> Administrative Service Contract *		<input type="checkbox"/> Prefund \$ _____ with monthly payment for claims

Previous Dental: Yes No If YES, List CARRIER, ADDRESS & EFFECTIVE DATES:

Honor Deductibles: Yes No If YES, list DEDUCTIBLE AMOUNT: \$

Current Orthodontics (takeover): Yes No

CURRENT YEAR-TO-DATE DEDUCTIBLE AND/OR MAXIMUM TAKEOVER LIST REQUIRED WITHIN 30 DAYS OF ACTIVATION DATE FOR EXPERIENCE-RATED AND ASC GROUPS.

PLAN RATE CALCULATION

Rate Calculation:	Number of Employees	Multiply	Rate	Monthly Premium (Rate x Employees)	Payments and Billing
Employee Only		X	\$	\$	Payments will be made via: <input type="checkbox"/> ACH (company initiated via website) <input type="checkbox"/> ACH (Delta Dental of Idaho draft) <input type="checkbox"/> Paper check Billing is available electronically. <input type="checkbox"/> Check if you prefer paper billing
Employee + Spouse		X	\$	\$	
Employee + 1 Child		X	\$	\$	
Employee + 2 or more Children		X	\$	\$	
Employee + Spouse + 1 or more Children		X	\$	\$	
TOTAL NUMBER OF EMPLOYEES			TOTAL MONTHLY PREMIUM	\$	

DELTA DENTAL OF IDAHO
555 E Parkcenter Blvd
Boise, ID 83706

SALES TEAM
(208) 489-3583
(800) 718-3374 Toll Free

Fax: (208) 489-3557
Email: sales@deltadentalid.com
deltadentalid.com

Group Application for Dental Benefits

(FOR 2 OR MORE EMPLOYEES, CONTINUED...)

UNDERWRITING REQUIREMENTS

General guidelines for all employers with 2 to 99 eligible employees

1. Voluntary plans do not require any employer contribution toward employee dental premiums.
2. Groups must maintain a minimum of two (2) enrolled employees.
3. Minimum enrollment of 35% of eligible employees is required for voluntary groups.
4. A group must consist of 75% or more of Idaho residents or a surcharge may apply.
5. Companies must be in business at least twelve (12) months.
6. The previous deductible will be honored providing the covered employee has proof of deductible taken during the calendar year, and prior to enrollment with Delta Dental.
7. Coverage will terminate for an eligible employee on the last day of the month in which employment terminates.
8. Industry Restrictions: Due to high turnover trends and/or lack of employee/employer relationship, some industries, such as restaurants, gas stations, insurance (commissioned agents), hotel, motel, retail, beauty/barber shops and real estate (commissioned agents), are restricted and may deviate from the eligibility and underwriting requirements.
9. Late Enrollee Provision: Any employee and/or their dependent(s) who do not enroll in the dental plan following completion of the employee's eligibility period, as defined above, will have a 12-month waiting period for Major Services and, if applicable, Orthodontic Services.

ELIGIBILITY OPTIONS

1. Married employees will enroll: Separately Under one rate category
2. Eligible employees work _____ hours per week.
3. Employees become eligible for benefits the first of the month following (check one): 3 months 2 months 1 month Other _____
4. The employer contributes _____ % toward the employee dental premium.
5. The employer contributes _____ % toward the dependent dental premium.
6. Employees who have not reached the end of their probation period are eligible: At group initial enrollment After completion of probationary period

PRODUCER OF RECORD (The Producer/Agent indicated below is hereby designated as our Producer/Agent of Record for dental coverage.)

Producer/Agent Name:		Agency Name:			
Phone:		Fax:		Email:	
Address:			City:		State:
					Zip:
Make Commission Checks Payable To: <input type="checkbox"/> Producer <input type="checkbox"/> Agency				Producer or Agency Taxpayer I.D.#:	
Producers and Agencies MUST be licensed with the Idaho Department of Insurance and appointed with Delta Dental of Idaho.				Idaho License #:	

AGREEMENT (This agreement will be in force per the terms of the Contract)

Applicant Name (please print):					
Name of Decision Maker (please print):			Title:		
Decision Maker's Signature:			Date Application Signed:		
DELTA DENTAL USE ONLY			Check Amount:		Date Approved:
NAICS:	County:	LMA:	Lock Box Receipt Number:		Group Number:
Territory: <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three			Date Received:		Effective Date:
Vendor Number:		Commission:	Received by:		

Groups Must Be Approved By Underwriting Before Coverage Begins. This Is Not A Contract.

Delta Dental of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 356-7586.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-(800) 356-7586.