DELTA DENTAL

Application and Agreement for Employers

Plan Option Selected: _____(please attach copy of proposal)

1) Group Name:_____

2) Requested Effective Date:_____ Renewal Date: _____

3) Group Physical Address: _____
PO Box if needed for Mailing:_____
City:_____ State: ____ Zip:_____ Telephone:_____
Fax:_____Tax Identification Number:_____
Type of Industry: _____ NAICS/SIC CODE_____

4) Contacts:

Group Executive who can sign the group contract and review renewal information:

Name & Title:_____ Email:_____

Daily Contact for general questions:

Name & Title:_____ Email:_____

Mailing Contact:_____Email:_____

Billing Contact:_____ Email:_____

5) Eligible Dependents will be covered to the end of the month in which they turn Age 26.

6) New Employee Probationary Period: Coverage not effective until the first day of the month following:
☐ 30 days ☐ 60 days ☐ 90 days ☐ date of hire or Other_____

7) Employee termination date will be end of the month, unless approved in advance in writing by Delta Dental.

8) Please choose one of the following Enrollment Options (*):
☐ Option 1: Annual Open Enrollment – If an employee waives coverage at time of eligibility, the employee will only be able to enroll during the group's annual open enrollment period. There will be no waiting periods for enrollment or changes made during the open enrollment period.

OPEN ENROLLMENT Changes effective on the 1st of _____(month)

☐ Option 2: Late Entry Provision – If an employee waives coverage at time of eligibility, the employee may enroll in any month of the year, but will have a 12 month waiting period for major services and orthodontia (as applicable).

(*)Please note if an option is not selected, the plan will automatically default to open enrollment with the contract renewal date being the effective date for open enrollment.

9) Employee Information:
Number of Full Time Eligible Employees:_____ Number of Enrolled Employees: _____

10) Employer Contribution for Employee Dental Coverage: _____
Employer Contribution for Employee Vision Coverage: _____

11) List Prior Dental Carrier: _____List Prior Vision Carrier:_____
Deductible/Maximum Credit from Prior Carrier? Yes ☐ No ☐
If yes, a report from the prior carrier is required for deductible and maximum credit.

12) If this plan is replacing an existing dental plan, a copy of the prior dental benefits must be provided by the previous carrier to receive credit as a takeover group.

13) Enrollment by: Paper ☐ Electronic Media ☐

14) For Groups with over 100 employees: ERISA Information Schedule A (Form 5500) Required?
Yes ☐ No ☐
If yes, indicate time period: (circle one): Calendar Year; Plan Year or other_____

15) Does the group require separate sub-locations or sub-groups? Yes ☐ No ☐ (these will be mirrored if vision is selected) If so, provide a list of the locations or groups. Eligibility must indicate the location or group in which the individual should be enrolled.

16) Number of hours worked in order to be considered full time and eligible for coverage _____

17) ID cards will be sent to the employee's home address unless otherwise requested by the group and noted in the Special Instructions (see below).

18) Billing Options ☐ Paper ☐ On-Line Billing

19) To utilize Electronic On line Web Enrollment or On-Line Billing: Please complete the attached Web Agreement Form.

INITIAL PAYMENT ONLY (binder check) MUST be sent with the new group forms to:

Attn: Marketing Dept.
Delta Dental of AR
P. O. Box 15965
Little Rock, AR 72231

Delta Dental Rates
Please use the rates listed on your proposal

Tier	*Number enrolled*	*Rates*
Employee Only		$
Employee +Spouse or Employee + One		$
Employee + Child/ren		$
Employee + Family		$

DeltaVision Rates
Plan # Selected:_____

Tier	Number enrolled	Rates
Employee Only		$
Employee +Spouse or Employee + One		$
Employee + Child/ren		$
Employee + Family		$

Special Instructions from Group:

_____
_____
_____
_____
_____

Authorized Signature and Agreement

On behalf of the Group identified above, the undersigned duly authorized representative hereby certifies that the information, terms and provisions in this Application and Agreement are complete, true and correct. The undersigned agrees that submission of this Application containing a false statement, material misrepresentation, or omission may constitute insurance fraud and may result in termination of coverage from the effective date of the Group Agreement. The undersigned further agrees that in making this Application the Group agrees to the terms and provisions of the Group Contract to be provided by Delta Dental of Arkansas (DDAR) of which this Application becomes a part following DDAR's decision to provide coverage to the Group. The undersigned acknowledges that DDAR will consider this information along with the Group's experience, enrollment data, and any other applicable information as part of the Group's application to DDAR for coverage. Coverage or administration for the Group will not be effective until the Group receives approval in writing from DDAR and current coverage should not be cancelled prior to such approval. The Group agrees that absence of written approval from DDAR does not imply acceptance by DDAR. Depending on the plan chosen by the Group, there may be minimum enrollment requirements. Rates are subject to change based on final enrollment data and any plan design changes. It is agreed the Group has 15 days from the date of delivery of the Group Contract to return the Group Contract to DDAR's corporate headquarters for cancellation of the Group Contract and a full refund. If the Group exercises this cancellation right, the Group Contract will terminate on the Group Contract's original effective date as if no coverage or administrative services were ever in force, and all money received will be returned. However, if claims were incurred in this 15-day period, the Group agrees to issue a refund to DDAR or, at DDAR's option, DDAR will reduce the amount of the refund otherwise payable to the Group for all amounts paid by DDAR toward these claims. This Application is subject to approval, refusal, or modification in accordance with DDAR's guidelines.

GROUP	DELTA DENTAL PLAN OF ARKANSAS, INC.
Executive Signature: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____
Agent: _____	

Fraud Warning:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Agents Only *(This Page is Not Part of the Group Contract)*

Agent Name: _____ Agency Name: _____
Complete Agency Address _____
Checks To: □ Company Tax ID: _____
Checks To: □ Agent Social Security Number: _____
E-Mail Address: _____
Telephone: _____ Fax:_____
New Agent/Agency? □ Yes □ No
(If Yes, Attach Agent Agreement and Copy of State License)
Commission Based on Standard Schedule? □ Yes □ No
Commission: _____%
Percentage of Split to this Agent: _____% (If Applicable)
Complete Physicial Address for mailing New Groups Supplies (**NO PO Box)**

_____
_____

If Commissions Are to Be Split, Complete the Following:

Agent Name: _____ Agency Name: _____
Checks To: □ Agent □ Company Tax ID: _____
Street Address: _____
E-Mail Address: _____
Social Security Number: _____
Telephone: _____ Fax:_____
New Agent/Agency? □ Yes □ No
(If Yes, Attach Agent Agreement and Copy of State License)
Commission Based on Standard Schedule? □ Yes □ No
Commission: _____%
Percentage of Split to this Agent: _____%

If Commissions Are Non-Standard, Complete the Following:

If a non-standard commission applies to this group, this "For Agents Only" page will serve as an addendum to this Agent/Agency Agent Fee Agreement **for this group only** when signed by the appropriate representatives of the Agent/Agency and DDAR.

Both the Agent/Agency and DDAR agree to the commission as stated in this addendum for this group as signed below:

Agent/Agency	**DDAR**
Signed: _____	Signed: _____
Title: _____	Title: _____
Date:_____	Date:_____

www.deltadentalar.com

WEB ACCESS AUTHORIZATION FORM

ELIGIBILITY MAINTENANCE

CLIENT NAME: _____ CLIENT NUMBER: _____

SUBCLIENTS(S): ☐ ALL ☐ Specific Locations: _____

Are you an AGENT who currently has access to the DDAR Employer Toolkit? ☐ YES ☐ NO

If YES, list User Name: _____

Please use a separate form if multiple users require access.

AUTHORIZED USER'S NAME: _____

AUTHORIZED USER'S EMAIL: _____

(Password will be e-mailed to this address)

Eligibility Access Options:
VIEW ONLY ☐ FULL ACCESS TO UPDATE ☐

ONLINE BILLING

IF ONLINE BILLING IS DESIRED THIS SECTION MUST BE COMPLETED

Once this section is complete paper bills will be turned off and electronic bills will be available online.

Online Billing Access Options:
VIEW BILL ONLY ☐ VIEW & ADJUST BILL ☐ VIEW, ADJUST, & FINALIZE BILL ☐

On Behalf of_____ (Group Name), and with the authority to act on behalf of this group, I understand and consent to the following:

1. The group's monthly bill will be posted electronically to the DDAR website. It is the group's responsibility to retrieve the bill from the website.
2. The only bill the group will receive will be the electronic bill.
3. The group is responsible for paying the bill no later than the 1st day of every month.
4. The group must inform DDAR of any changes to its authorized user's email address, so DDAR can send the group notices regarding its bills. The group is still responsible for timely payment of its bill, regardless of such notices.

TERMS AND CONDITIONS OF USE

Delta Dental of Arkansas (Delta Dental) permits Groups to open Website Accounts for Authorized Individuals for purposes of submitting timely, accurate and complete Group enrollment data to Delta Dental on the Group's behalf. The Group, acting through its undersigned representative, certifies that the users identified in this application are authorized to submit enrollment data to Delta Dental on the Group's behalf and, in consideration for Delta Dental's grant of access via this Website Account, agrees to the following conditions: (1) Delta Dental may rely on this electronically submitted enrollment data to the same extent as if submitted by non-electronic means; (2) Group will undertake reasonable measures to safeguard account information, including username and password, and to prevent unauthorized access to the Website by someone acting or purporting to act on the Group's behalf; (3) All requests to close the Website Account must be submitted in writing to Delta Dental via fax to 501-992-1899, Delta Dental shall have three business days (excluding holidays) to close the Website Account; (4) Group shall be solely responsible for any liability arising from the use of the Website Account and shall indemnify, hold harmless and defend Delta Dental against any claim arising from the Authorized User's use of the Website Account or the Group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws; and (5) the individual signing this application has the authority to permit the requested access and bind the Group to the terms and conditions set forth above.

Group Administrator: _____ Phone Number: _____

Group Administrator's Signature: _____ Date signed: _____

Once completed, please fax the form to your appropriate DDAR Account Manager. After the form is processed, you will receive two emails, the first with your username, and the second with your password. Once your bill is ready, you will receive a notification email stating your bill is available for viewing. If you have any questions regarding your bill, please contact your Billing Auditor for assistance.

E-COMMERCE AGREEMENT

I request that Delta Dental of Arkansas email the group policy, enrollee certificates, and all other information regarding my group's dental insurance with Delta Dental of Arkansas. I will inform Delta Dental of Arkansas in writing of any transactions I do not wish to conduct electronically.

Signature: _____ Date: _____

Email address: _____