DELTA DENTAL®

SMALL BUSINESS PROGRAM
GROUP DENTAL APPLICATION

Delta Dental Insurance Company
Alpha Dental of Nevada, Inc.
1130 Sanctuary Parkway
Alpharetta, GA 30009
888-858-5252

APPLICANT INFORMATION			
Name of Applicant:		Fed. ID/TIN:	
Contact:		Phone:	
Email:		Fax:	
Address:			
City:	State:	ZIP Code:	County:
Industry Type:		SIC:	
Billing Address, if different:			
Billing Contact:		Phone:	Fax:
Billing Email:			
Situs State: Nevada	Group Type: Employer	Contract Type: Non Retention	Length of Contract: 2 years
Proposed Effective Date:			
Recipient of Electronic Documents and Notices: ☐ Applicant ☐ Other (provide name and email, address or fax number):			
I, the Contract holder, authorize the broker to manage eligibility on my behalf: ☐ Yes ☐ No			
Name of prior dental carrier:			

DELTA DENTAL PPO™ BENEFIT DESIGNS – Underwritten by Delta Dental Insurance Company				
	CORE		**ADVANTAGE**	**DELUXE**
Select a Dental PPO plan	**PPO:** ☐ /2ℕŜ нлл	**PPO:** ☐ /2ℕŜ млл	**PPO:** ☐ !ŘØl·yűl·∃Ŝ плл **PPO Plus Premier™:** ☐ !ŘØl·yűl·∃Ŝ олл ☐ !ŘØl·yűl·∃Ŝ нлл ☐ !ŘØl·yűl·∃Ŝ млл	**PPO:** ☐ 5ŜfdzÈŜ олл **PPO Plus Premier:** ☐ 5ŜfdzÈŜ нлл ☐ 5ŜfdzÈŜ млл
/l·fŜyŘl·ℕ ¸Ŝl·ℕ a l·ÈλYdzY ótŜℕ 9yℕ2ffŜŜú	☐ Рм∑ллл	☐ Рм∑ллл ☐ Рм∑рлл	☐ Рм∑ллл ☐ Рм∑рлл ☐ Рн∑ллл ☐ Рн∑рлл	☐ Рм∑рлл ☐ Рн∑ллл ☐ Рн∑рлл ☐ Ро∑ллл
Orthodontic Services (Optional)			☐ No ☐ Child Only	☐ No ☐ Child Only ☐ Adult & Child
Orthodontic Lifetime Maximum (Per Enrollee)			☐ $1,000 ☐ $1,500	☐ $1,500
D&P Maximum Waiver®			☐ Yes ☐ No	

DELTACARE® USA BENEFIT DESIGNS – Underwritten by Alpha Dental of Nevada, Inc.			
	CORE	**ADVANTAGE**	**DELUXE**
Select a DeltaCare USA plan	☐ 17B	☐ 15B	☐ 11A

DELTA DENTAL'S DUAL CHOICE BENEFIT DESIGNS

☐ Dual Choice 1 - Choose any one Delta Dental PPO plan and any one DeltaCare USA plan from above

☐ Dual Choice 2	**D&P Maximum Waiver** ☐ Yes ☐ No	**Orthodontic Services (Optional)** ☐ No ☐ Child Only	**Calendar Year Maximum (Per Enrollee)** ☐ $1,500 ☐ $2,000
☐ Dual Choice 3	**D&P Maximum Waiver** ☐ Yes ☐ No	**Orthodontic Services (Optional)** ☐ No ☐ Child Only	**Calendar Year Maximum (Per Enrollee)** ☐ $1,000 Low/$1,500 High ☐ $1,500 Low/$2,500 High
☐ Core/Buy-Up	**Fee Basis (select one)** ☐ PPO ☐ PPO Plus Premier	**Orthodontic Services (Optional)** ☐ No ☐ Child Only	**Calendar Year Maximum (Per Enrollee)** ☐ $1,000 Core/$1,500 Buy-Up ☐ $1,000 Core/$2,000 Buy-Up

CONTRIBUTION AND PARTICIPATION

PPO Employer Contribution and Participation Requirement (check one):

☐ 100% All eligible employees ☐ 75%-99.9% 75% of eligible employees ☐ 50%-74.9% 50% of eligible employees ☐ 0%-49.9% (Voluntary Plan Only)

For groups with 5 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 5 primary enrollees. For groups with 2-4 eligible enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.

DeltaCare USA Employer Contribution Requirement (check one):

☐ At least 75% for employees and dependents ☐ At least 75% for employees ☐ Less than 75% for employees

Enrollment may not be less than 2 primary enrollees.

PPO Core/Buy-Up Employer Contribution* and Participation Requirement (check one):

☐ 100% All eligible employees ☐ 75%-99.9% 75% of eligible employees ☐ 50%-74.9% 50% of eligible employees

Combined enrollment, in both the Core and Buy-Up options, may not be less than the greater of the percentage listed above or five primary enrollees.

*Employer contribution is based solely on the Core rates.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

Rates and Enrollment				Second Plan if Dual Choice is Selected			
	Monthly Rates	#Primary Enrollees	Total		Monthly Rates	#Primary Enrollees	Total
3 Tier							
EE Only	$	x	= $	EE Only	$	x	= $
EE+1	$	x	= $	EE+1	$	x	= $
EE+2 or more	$	x	= $	EE+2 or more	$	x	= $
4 Tier							
EE Only	$	x	= $	EE Only	$	x	= $
EE+Spouse	$	x	= $	EE+Spouse	$	x	= $
EE+Child(ren)	$	x	= $	EE+Child(ren)	$	x	= $
EE+Family	$	x	= $	EE+Family	$	x	= $
		TOTAL	$			**TOTAL**	$

ELIGIBILITY INFORMATION

Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):

# of Eligible Employees:

PPO*	**DeltaCare***	**Dual Choice PPO**
# of Enrolled Employees:	# of Enrolled Employees:	# of Enrolled Employees (Low/Core/PPO Plus Premier): # of Enrolled Employees (High/Buy-Up/PPO):

Eligible Individuals (check applicable boxes): ☑ Eligible Employees ☐ Retired Employees

Eligible Dependents (check applicable boxes): ☑ Spouse ☑ Children ☐ Domestic Partner ☐ Others

Eligible Requirement (check one): ☐ Date of hire ☐ First of the month following date of hire
☐ First of the month following _____ days of employment

* If electing Dual Choice 1 populate both DPO and DeltaCare enrolled employee fields.

Application is herewith made for a dental insurance contract from Delta Dental Insurance Company (Delta Dental). It is understood that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the plan. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta Dental's designated administrator and accepted by the administrator on behalf for Delta Dental, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered as an inducement for issuance of a dental insurance contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant.

This plan shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility list will be submitted to Delta Dental's designated administrator by the 25th of the month prior to the coverage month.***

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations (''HIPAA''), Applicant shall provide Delta Dental's designated administrator with Protected Health Information (''PHI'') for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental plan as described in the group dental insurance contract or as permitted or required by law. Delta Dental and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental insurance contract to be executed between the Applicant and Delta Dental.

Executed this _____day of_____20_____, for the Applicant at:_____
(City and State)

By:_____ Signature: _____
(Print Name and Title)

Delta Dental Authorized Signature: _____
Michael G. Hankinson, Esq., EVP, Chief Legal Officer

BROKER/AGENT INFORMATION			
Broker/Agent Name:		State License:	
National Producer Number:			
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? ☐ Yes ☐ No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
Broker/Agent Signature:		Date:	

GENERAL AGENT INFORMATION			
General Agent Name:		State License:	
National Producer Number:			
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? ☐ Yes ☐ No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s):	Payable to:		
General Agent Signature:		Date:	

ELECTRONIC DELIVERY OF DOCUMENTS TERMS AND CONDITIONS

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your Dental contract-related documents made available to you electronically. If you choose to have your contract-related documents made available to you electronically, the terms & conditions below apply.

1. Communication Methods: All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental or Delta Dental's designated administrator website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.
2. Types of Documents that Will Be Electronically Communicated: Documents available electronically include, but are not limited to: your contract, the Evidence of Coverage (Certificate/EOC) for your enrollees and your notifications.
3. How to Withdraw Consent: You may withdraw your consent to transact business electronically by contacting Delta Dental's designated administrator. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic Communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.
4. How to Update Your Records: It is your responsibility to provide us with true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information by contacting Delta Dental's designated administrator.
5. Hardware and Software Requirements: In order to access, view, sign and retain electronic documents that we make available to you, you must:
    - Have a device that will connect to the Internet, access to an email account and access to an internet browser.
    - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
    - Be able to view the disclosures on your device.
    - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.

☐ **Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents provided electronically.**

Delta Dental Administrator's Use ONLY

Application accepted on: _____

Delta Dental PPO Group #: _____
DeltaCare USA Group #: _____
Delta Dental Secondary PPO Group #: _____

TPA Employer #: _____
TPA Employer #: _____
TPA Employer #: _____