MN New Business Checklist

Please confirm that the following is submitted with all new cases.

- ❑ Completed application for group dental insurance
- ❑ Completed employee enrollment forms or census spreadsheet *(census is preferred for ease of processing)*
- ❑ Sold Quote with elected plan and rates from www.directbenefits.com
- ❑ If paying by ACH, please complete the included form and provide a copy of a voided check
- ❑ A Binder Check is not required if not paying by ACH. Clients may wait until their first bill to send payment to Delta Dental.*

If applicable, please confirm that all of the following documentation is provided prior to coverage on take-over cases:

- ❑ Copy of Prior Carrier's summary of benefits
- ❑ Copy of Prior Carrier's most recent billing statement

Policy Documents Delivery Acknowledgement

Policy documents will be delivered how requested on the master application. ID cards will be mailed to the employer for distribution.

After all the information listed above is completed and signed, submit all forms using one of the following delivery methods:

Email: agentsupport@directbenefits.com

Fax: **651-649-3502 ATTN: Group Sales**

Mail: **Direct Benefits, Inc.**
55 East 5th Street, Suite 500
Saint Paul, MN 55101

***Payment by check may be sent to Delta Dental directly at the following address:**

Delta Dental of Minnesota
ATTN: Group Billing
NW 5772 PO Box 1450
Minneapolis, MN 55485

Submission Date:
New groups should be received no later than the 10th of the month of the desired effective date in order to submit to the carrier (*i.e. Feb 1st effective date, please submit to Direct Benefits by Feb 10th)*.

Delta Dental of Minnesota

500 Washington Ave South
Suite 2060
Minneapolis, MN 55415-1163
www.DeltaDentalMN.org

DirectBenefits
AN ALERA GROUP COMPANY

55 Fifth Street, East
Suite 500
Saint Paul, MN 55101
Phone: 1-800-620-5010
Fax: 651-649-3502
www.directbenefits.com

Master Application
Delta Dental PPO Plus Premier – Pathfinder Plans

PART A – Company Information

Legal Company Name ______________________________

Address ______________________________ Phone ( ) ______________

____

City ______________________________ State ____________ Zip Code ____________

Plan Effective Date: ______________________________

Eligibility probationary period for new employees: First of the month following ______________________________

Other ______________________________

Does your company currently have a dental plan? ☐No ☐Yes (name of carrier) ______________________________

(Attach a copy of current billing statement and benefit summary) Prior Plan Start Date: ______________________________

Waiting Periods and Takeover Benefits:

Waiting Periods Waived for Prior Comparable Coverage

If a group has at least 12 continuous months of prior comparable employer paid coverage, and no gap between that coverage and the Pathfinder effective date, all members of the group will receive a waiver of Pathfinder waiting periods, with the following exceptions: The waiver does not apply to employees/dependents who join the group or enroll for Pathfinder coverage after the initial Pathfinder effective date.

Credit of $100 Lifetime Deductible

If a group has at least 12 continuous months of coverage with a $100 lifetime deductible on its prior dental plan and converts to a Pathfinder plan with a $100 lifetime deductible, members of the group will receive credit for the $100 deductible.

Client Contact Information

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.**

First Name ______________________________ **Last Name** ______________________________

Title ______________________________

Contact Type: ☐ **General** ☐ **Renewal** ☐ **Billing** ☐ **Mailing** ☐ **Materials** [☐ **Overage Dependent**]

Telephone: ______________________________ Ext: ____________ Cell: ______________________________

Fax: ______________________________ Email Address: ______________________________

☐ Same as Client Physical Location

Mailing Address: ______________________________

City ______________________________ State ______________________________ Postal Code ______________

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name ______________________ Last Name ______________________

Title ______________________

Contact Type: ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials [☐Overage Dependent]

Telephone: ______________ Ext: ________ Cell: ______________

Fax: ______________ Email Address: ______________

☐ Same as Client Physical Location

Mailing Address: ______________________

City ______________ State ______________ Postal Code ______________

Client – Employer Services Portal Registration

With the Employer Services Portal, you can enroll a new member, update existing members, view eligibility and dental benefits. In addition, **your monthly invoice and other billing details are provided to you *exclusively* through the Employer Services Portal.**

Select a Client Administrator within your company and complete the information below. This Client Administrator will create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will e-mail the Client Administrator with registration information and additional instructions.

Client Administrator Name: ______________ Title: ______________

Email: ______________ Phone Number: ______________

Note: The Client Administrator must be an employee of the client

PART B - Participation

TOTAL NUMBER OF ELIGIBLE EMPLOYEES ______________

Please check (✓) below:

☐ 2-100 Employees Enrolled – [**Annual Open Enrollment]** – Minimum of 2 employees must enroll.

PART C – Dental Program (choose one):

All programs require completion of a Pathfinder Plan Census/Enrollment Spreadsheet

Pathfinder Plans 1-6

- ☐ **Pathfinder Plan 1 - $50/$150 deductible, $1000 annual maximum**
- ☐ **Pathfinder Plan 2 - $100/$300 deductible, $1500 annual maximum**
- ☐ **Pathfinder Plan 3 - $50/$150 deductible, $1500 annual maximum, plan waiting periods do not apply**
- ☐ **Pathfinder Plan 4 - $50/$150 deductible, $1500 annual maximum, orthodontic coverage for age 8 up to age 19, $1000 orthodontic lifetime maximum**
- ☐ **Pathfinder Plan 5 - $100/$300 deductible, $1500 annual maximum, 24 month initial contract**
- ☐ **Pathfinder Plan 6 - $100/$300 deductible, $1500 annual maximum, plan waiting periods do not apply**

Pathfinder Plans 1-6

2 - 100 Enrolled Employees

Rates Sold

Single ______________
Single + Spouse ______________
Single + Child(ren) ______________
Family ______________

PART D – Orthodontics:

Does the prior dental plan have orthodontic coverage? ☐ Yes ☐ No

☐ **Child Orthodontics** (For Pathfinder Plan 4 Only)
Please check (✓) below

Orthodontic Coverage - minimum of 2 enrolled employees. Coverage for age 8 up to age 19, Coverage at 50%, Lifetime Orthodontic Plan Maximum $1,000, 12 month waiting period applies for new groups without 12 months of previous comprehensive coverage.

☐ $1,000 Lifetime Orthodontic Maximum

Please Note: If you are adding orthodontics and the previous dental plan did not have prior, comparable orthodontic coverage, there will be a 12-month waiting period for orthodontic benefits.

PART E – Broker of Record (if any) Completion of all fields is required

Broker Name ______________________________ **Agency** ______________________________

Address ____

City ______________________________ **State** __________ **Zip Code** ______________

Phone ______________________________ **E-mail Address** ______________________________

______________________________ ______________________________

Broker Signature / Insurance Broker License ID Number **Tax ID Number**

Note: Commissions will be paid to this TIN

<u>Broker Services Portal</u>

With the Broker Services Portal, the Broker of Record can update and view the client's eligibility and access the client's billing details. The Broker/Agency will work with their Agency's Broker Administrator, who will add the appropriate user permissions to the Broker's access.

PART F – Premium Remittance

The first month's premium payment must be received in order for Delta Dental to pay claims for your members. Please submit your first month's premium with your application.

Instructions:

1. Complete Delta Dental PPO Plus Premier – Pathfinder Plan Master Dental Contract Application.
2. Each eligible employee must complete and sign a Pathfinder Plan Membership Enrollment Form, or be identified on an approved Enrollment spreadsheet completed by Client Administrator.
3. Send the original Delta Dental PPO Plus Premier – Pathfinder Plan Master Dental Contract Application, completed Pathfinder Plan Enrollment Forms or approved Enrollment Spreadsheet, copy of corresponding Dental Proposal(s), a check for first month of premium payable to Delta Dental, along with current prior carrier billing statement and benefit summary, if applicable, to:

Direct Benefits, Inc.
55 Fifth Street, East, Suite 500
Saint Paul, MN 55101

Please Select Payment Option:

☐ ACH - Automatic Check Handling (Include ACH Authorization Form and voided check)

☐ Check

For questions call Direct Benefits at 800-620-5010

Client Administrator:
By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the Company (Company as named in Part A above) and agree to provide substantiating evidence when requested.

If Delta Dental accepts this application, Delta Dental will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

SIGNATURE BOX

Signature	Title	Date

Delta Dental PPO plus Premier- Pathfinder Plan

Fully-Insured Groups

Automated Clearinghouse Authorization Agreement

Company Name ______________________________

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the ***Total Amount Due*** according to our Invoice / Statement. Premium will be taken on the first business day of each month

Group Number ______________

ACH Effective Date ______________________________

Bank Name ______________________________

Bank Address ______________________________

Bank Account Number ______________________________

Type of Account ☐ Checking ☐ Savings

Bank Account Name ______________________________

Bank Routing Number ______________________________
(between these symbols ⑆ ⑆ on the bottom left of your check)

PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account ______________________________
Print

____
Signature Today's Date

____
Title Telephone Number

____
E:Mail address

Questions? Please call our Billing and A/R Department at: 651-406-5902 or 1-800-906-4702

Please complete this form and fax to us at: 1-877-803-2433.

or,

Please complete this form and mail to:

Delta Dental of Minnesota
ATTN: Billing and Accounts Receivable
P.O. Box 9304
Minneapolis, MN 55440-9304

Delta Dental PPO plus Premier – Pathfinder Plan

Membership Enrollment Form

Delta Dental of Minnesota

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last	First	Middle Initial	**Social Security Number** / /
Gender:	Male ☐ Female ☐	**Marital Status:**	Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address		Day Phone Number	Evening Phone Number
	City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type – W ho Is Being Enrolled – Check One Box Only

☐ Employee only*
☐ Employee and Spouse
☐ Employee and Dependent Child(ren)
☐ Family
☐ No Coverage * If waiving coverage for employee and/or any eligible family members, complete Part D.

PART C – DEPENDENT INFORMATION

Relationship To Employee	**First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)**	**Gender**	**Date of Birth Month/Day/Year**	**Full time Student?**	**Unmarried?**
☐Spouse ☐Domestic Partner		M F	/ /	Y | N	Y | N
Dependent Child		M F	/ /		
Dependent Child		M F	/ /		
Dependent Child		M F	/ /		

PART D – OTHER INSURANCE COVERAGE – Complete if employee and/or eligible dependents are not being enrolled.

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: ______________________ Policy/Identification Number: ______________________

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: **Date:**

PART E – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: **Date:**

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: ________/_________/_________
Prior Coverage Start Date (if applicable): _________/_________/_________
Coverage Effective Date: _________/_________/_________

☐ **Existing Delta Dental Group**
Hire Date: ________/_________/_________
Prior Coverage Start Date (if applicable): _________/_________/_________
Coverage Effective Date: _________/_________/_________

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date: ___________ /_______/________
Effective Date:_______ /________/________

☐ **Open Enrollment**
Effective Date:
_______ /________/________

☐ **Rehire** Date Lay Off Began: _________/_________/________
Date Rehired: _________/_________/________

☐ **Return from Leave of Absence**
Date Leave Began: _________/_________/_________
Date Returned to Work: _________/_________/_________

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _________ /_________/_________
Effective Date: _________ /_________/_________

☐ **Previously Waived Coverage or Loss of Coverage**
Qualifying Event Reason:____________________________
Hire Date: ______________ /_______/_________
Event Date: ____________ /_______/_________
Effective Date: _________ /_______/_________

Group Name: **Group & Subgroup Numbers**:

Group Representative's Signature: **Date:** **Phone Number:**