

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*)
- Online agent-generated proposal from [www.directbenefits.com](http://www.directbenefits.com)
- If paying by ACH, please complete the included form and provide a copy of a voided check
- If paying by check, include a copy of the Binder Check

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](mailto:agentsupport@directbenefits.com)

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

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

**\*Please send hard copy of binder check to the address above**

#### Submission Date:

New groups should be received no later than the 8th 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 8th*).





Delta Dental of Minnesota



Master Application
Delta Dental Small Business Clients

PART A - Client Information

Legal Company Name

Physical Address Phone ( )

City State Zip Code

Mailing Address Same as client physical location

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)

(Include a copy of most recent billing statement and benefit summary) Prior Plan Start Date:

Total Number of Eligible Employees

Client Contact Information

Mr. Mrs. Ms. Dr.

First Name Last Name

Title

Contact Type: General Renewal 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 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 – Delta Dental PPO Plus Premier™ Dental Program Options (choose only one)**

**Delta Dental PPO Plus Premier™ - Delta Dental Solutions Dual Option:** Available for groups with 2 - 100 eligible employees, minimum of 2 employees must enroll. [Annual Open Enrollment]

Orthodontic Coverage - minimum of 2 enrolled employees. Coverage for age 8 up to age 19, Coverage at 50%, Lifetime Orthodontic Plan Maximum \$1,000.

- Yes, we accept orthodontic coverage
- No, we decline orthodontic coverage

Please confirm sold plan rates

Employee \_\_\_\_\_  
Employee + 1 \_\_\_\_\_  
Employee + Child(ren) \_\_\_\_\_  
Family \_\_\_\_\_

**Delta Dental PPO Plus Premier™ - Delta Dental Solutions 1000, 1500, and 2000:** Available for groups with 2 -100 eligible employees, minimum of 2 employees must enroll. [Annual Open Enrollment]

**Deductible**

Annual - \$50 per person/\$150 per family

**Annual Plan Maximum Options**

**Please check (✓) one below:**

- \$1,000 per person per year
- \$1,500 per person per year
- \$2,000 per person per year / with Orthodontic Coverage\*

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

Please confirm sold plan rates

Employee \_\_\_\_\_  
Employee + 1 \_\_\_\_\_  
Employee + Child(ren) \_\_\_\_\_  
Family \_\_\_\_\_

**Delta Dental PPO Plus Premier™ - Dental Flex:** Available for groups with [2-999] eligible employees, minimum of 2 employees must enroll. [Annual Open Enrollment]

**Annual Plan Maximum Options**

**Please check (✓) one below:**

- \$1,000 per person per year
- \$1,500 per person per year

**Orthodontic Coverage** - minimum of 2 enrolled employees. Coverage for age 8 up to age 19, Coverage at 50%, Lifetime Orthodontic Plan Maximum \$1,000, Lifetime Ortho Max matches Annual Plan Maximum selection, 12 month waiting period applies for new employees and groups without 12 months of prior comprehensive coverage.

- Yes, we accept orthodontic coverage
- No, we decline orthodontic coverage

Please confirm sold plan rates

Employee \_\_\_\_\_  
Employee + 1 \_\_\_\_\_  
Employee + Child(ren) \_\_\_\_\_  
Family \_\_\_\_\_

**PART C – Broker of Record - Completion of all fields is required**

<b>Broker Name</b>	<b>Agency</b>	
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Phone</b>	<b>E-mail Address</b>	
<b>Broker Signature / Insurance Broker License ID Number</b>	<b>Tax ID Number</b>	

**Note: Commissions will be paid to this TIN**

**BROKER SERVICES PORTAL**

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 D – Premium Remittance and Submission**

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.

1. **Select Payment Option:**  **ACH**     **Check** Make payable to: Delta Dental of Minnesota and mail payments to:  
Delta Dental of Minnesota, NW 5772, PO Box 1450, Minneapolis, MN 55485-5772
2. **Complete the Master Dental Contract Application. Retain a copy for your files.**
3. **Have each employee complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator.**
4. **Send the Master Dental Contract Application, completed Enrollment Forms or approved Enrollment spreadsheet, corresponding Dental Proposal, and the first month of premium to:**  
**Direct Benefits**  
**ATTN: Group Sales Department**  
**55 East 5th Street Suite 500**  
**Saint Paul, MN 55101**
5. **Completed applications and related materials may also be emailed to: [Deltadentalconnect@deltadentalmn.org](mailto:Deltadentalconnect@deltadentalmn.org)**

**For questions call 1-800-906-5250 or [DeltaDentalConnect@DeltaDentalMN.org](mailto:DeltaDentalConnect@DeltaDentalMN.org)**

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**

<b>Signature of Authorized Company Official</b>	<b>Title</b>	<b>Date</b>
<b>Client Administrator/Future Correspondence Contact (please print)</b>		<b>Title</b>
<b>Phone Number</b>	<b>Fax Number</b>	<b>Email Address</b>

**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

<b>Client Name</b>		<b>Client/Subclient #</b>		-	
<b>PART A - PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):</b>					
<b>Type of Update:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Change/Correction to Information <input type="checkbox"/> Termination <input type="checkbox"/> Transfer					
<b>Transfer From:</b> Client/Subclient #		<b>Transfer To:</b> Client/Subclient #		<b>Change is for:</b> <input type="checkbox"/> Subscriber <input type="checkbox"/> Dependent	
-		-		<input type="checkbox"/> Spouse/Domestic Partner	
<b>PART B - FOR MILLENNIUM CHOICE<sup>SM</sup> PRODUCT ONLY</b>			<b>Select a Plan Option:</b> <input type="checkbox"/> Plan Option I - Delta Dental PPO		
			<input type="checkbox"/> Plan Option II - Delta Dental Premier		
<b>PART C - SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):</b>					
<b>Subscriber Name (Last)</b>		<b>(First)</b>		<b>(Middle initial)</b>	<b>Gender</b>
<b>Social Security Number</b>	<b>Birth Date (Month-Day-Year)</b>	<b>Effective Date (M/D/Y)</b>		<b>Hire Date (M/D/Y)</b>	
<b>Street Address</b>				<input type="checkbox"/> Check here if this is a new address	
<b>City</b>	<b>State</b>	<b>Zip Code</b>		<b>Status*</b> <input type="checkbox"/> Active <input type="checkbox"/> COBRA	
				<input type="checkbox"/> Retiree <input type="checkbox"/> Surviving	
<b>PART D - DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):</b>					
<b>Relationship to Employee</b>	<b>Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)</b>	<b>Gender</b>	<b>Date of Birth (M/D/Y)</b>	<b>Social Security Number-requested but not required**</b>	<b>Status*</b>
<b>Spouse/Domestic Partner</b>					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving
<b>Dependent Child</b>					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
<b>Dependent Child</b>					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
<b>Dependent Child</b>					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
<b>Dependent Child</b>					<input type="checkbox"/> Legal <input type="checkbox"/> Surviving <input type="checkbox"/> Disabled <input type="checkbox"/> Sponsored <input type="checkbox"/> Full Time Student
*see reverse side for instructions and explanation of codes					
**Social security number only requested for dependents with same date of birth					
<b>PART E - SUBSCRIBER AND CLIENT SIGNATURE - Sign and date form as verification of your enrollment</b>					
<input type="checkbox"/> I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.					
<input type="checkbox"/> 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.					
Do you or your dependents have other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
_____			_____		
Name of Carrier			Policy/Identification Number		
<b>Employee Signature:</b> _____			<b>Date:</b> _____		
<b>Client Representative Signature</b> _____			<b>Date:</b> _____		
<i>For Employer Use Only:</i>					
<i>Qualifying Event (see next page for list of qualifying events)</i> _____				<i>Date of Qualifying Event:</i> _____	

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your employer continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Plan Enrollment/Update Information - This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are not being reinstated or, 3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Transfers: When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

Enrollment/Corrections To Information - This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse or domestic partner

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's contract with Delta Dental.

Full Time Student: An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Qualifying Events (for Employer Use Only) -

A - Adoption	L - Loss of Coverage	T - Termination/Reduction of Work Hours
B - Birth	M - Marriage	V - Employee Total Disability
D - Divorce/Legal Separation	O - Open Enrollment	X - Employee Eligible for Medicare
E - Death	S - Dependent No Longer Eligible	



Email: [eligibility@mydeltadental.com](mailto:eligibility@mydeltadental.com)



Delta Dental  
Attention: Eligibility Department  
PO Box 30416  
Lansing, MI 48909-7916

## Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota and its affiliates, (collectively referred to herein as “Delta Dental of Minnesota”) comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Compliance Officer, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-448-3815 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-448-3815 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448-3815 (TTY: 711). (Vietnamese)

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 1-800-448-3815 (TTY: 711)。 (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815 (телетайп: 711). (Russian)



ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-448-3815 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-448-3815 (መስማት ለተሳናቸው: 711). (Amharic)

ဟံသုဂ်ບတ်သး- နမ့်ကတိၤ ကညီ ကျိၣ်ဆယ်, နမၤန့ၢ် ကျိၣ်ဆတ်မၤစၢၤလၢ တလၢ်ဘျုးလၢ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-800-448-3815 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815 (TTY: 711). (German)

711). رقم (1-800-448-3815 برقم اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا ملحوظة: ه الصم والبكم: (Arabic)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815 (ATS : 711). (French)

주의 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-3815 (TTY: 711)번으로 전화해주십시오 (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815 (TTY: 711). (Tagalog)

بكه. بهردسته (Kurdish) تو بۆ بهخۆراپی، زمان یارمهتی خزمهتگوزاریهکانی، دهکههیت قهسه کوردی زمانی به نهگهر: ناگاداری پ به 1-800-448-3815 (TTY: 711)

بگیرید. شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو فارسی زبان به اگر: توجه ف می باشد. با 1-800-448-3815 (TTY: 711) تماس (Persian / Farsi)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-448-3815 (TY:711) まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-448-3815 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistentsetjenester tilgjengelige for deg. Ring 1-800-448-3815 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षणः यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, निःशुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-448-3815 (TTY: 711) मा कल गर्नुहोस्। (Nepali)