DELTA DENTAL®

ND 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)*.

DirectBenefits
AN ALERA GROUP COMPANY

DELTA DENTAL
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

Serving North Dakota

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 1-5

☐ Pathfinder Plan 1 - $50/$150 deductible, $1000 annual maximum

☐ Pathfinder Plan 2 - $100/$300 deductible, $1000 annual maximum

☐ Pathfinder Plan 3 - $100/$300 deductible, $1500 annual maximum, 24 month initial contract

☐ Pathfinder Plan 4 - $100/$300 deductible, $1500 annual maximum

☐ Pathfinder Plan 5 - $100/$300 deductible, $1500 annual maximum, orthodontic coverage for age 8 up to age 19, $1000 orthodontic lifetime maximum, plan waiting periods do not apply

Pathfinder Plans 1-5

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 5 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 under all Pathfinder plans.

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

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 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 ofpremium 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

Delta Dental of Minnesota

DIRECT DEBIT AUTHORIZATION
VIA ACH (Automatic Withdrawals)

Client Name: _____

Client Number: _____

Client Sub-location Number(s): _____

Effective Date: _____

Financial Institution Information:

Bank Name: _____

Bank Address: _____

ABA (Routing) Number: _____

Account Number: _____

Type of Account: _____

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above in accordance with my underlying contract with Delta Dental and Delta Dental's ACH processing policies. I understand that I am responsible for any fees incurred due to the ACH being rejected or returned for any reason by my bank and collection action may be taken.

This authorization will remain in full force and effect until Delta Dental has received written notification from me of its termination in such time as to afford Delta Dental and the Financial Institution a reasonable opportunity to act on it, or until all of my payment obligations under the contract have been satisfied.

Should you have any questions regarding your Direct Debit (ACH) Instructions, please contact the Accounting Department at 1.800.906.4702 or AR@deltadentalmn.org

Mailing address: 500 Washington Avenue So, Suite 2060, Minneapolis, MN 55415

Office hours are Monday through Friday, 8 a.m. to 5 p.m. CST.

Authorized Signature: _____ Date: _____

Printed Name: _____ Phone Number _____

DELTA DENTAL

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		Male	/ /	Y | N	Y | N
Dependent Child		Male	/ /		
Dependent Child		Male	/ /		
Dependent Child		Male	/ /		

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:**