DELTA DENTAL®

Requested Coverage Effective Date

_____ / _____ / _____
MM DD YY

Master Application & Agreement for Business Clients

SECTION 1 — YOUR BUSINESS AND YOUR EMPLOYEE BENEFITS			
Business Name:			
Physical Address:	City:	State:	ZIP:
Mailing Address:	City:	State:	ZIP:
Telephone:	FAX:	Tax Identification Number:	
Type of Business:	NAICS Code:		

SECTION 2 — BUSINESS CONTACTS (Please provide contact information for the following people at your business.)	
Business Owner/Executive:	Title:
Telephone:	Email:
The Business Owner/Executive list above is the person who is authorized to sign this contract and agreement, grant access to employee Private Health Information (PHI), and review plan renewal information.	
Daily Contact for general questions:	Title:
Telephone:	Email:
Billing Contact:	Title:
Telephone:	Email:
Mailing Contact:	Title:
Telephone:	Email:

SECTION 3 — EMPLOYEE ELIGIBILITY
How many hours per week must an employee work to be considered full-time and eligible for benefits?
How many full-time, benefits eligible employees are at your business?
Does your business require separate locations or groups for benefits? ☐ Yes ☐ No
If yes, please provide a list of the locations or groups. NOTE: Enrollment details for each employee MUST indicate the location or group in which the employee is to be included.
When is a new employee eligible for coverage?: First of the month after: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other
How many employees have enrolled in your new Delta Dental benefits? ☐ Dental: ☐ Vision:

SECTION 4 — YOUR DELTA DENTAL BENEFITS

Which Delta Dental benefits has your business selected? (attach copy of your proposal if you received one)	☐ Dental Plan Name:
	☐ Vision Plan Name:

List employer contribution (percentage) for your Delta Dental benefits. If none, list 0%. Dental: Vision:

Is your Delta Dental plan replacing an existing: Dental plan? ☐ Yes ☐ No Vision plan? ☐ Yes ☐ No

If yes, please provide the name of your prior Dental insurance carrier.

If yes, please provide the name of your prior Vision insurance carrier.

Will Delta Dental be expected to give credit toward the deductible and annual maximum from your prior insurance carrier?

☐ Yes ☐ No ☐ N/A If yes, we require you to include a report from the prior carrier with this application/agreement to provide this credit.

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 for prior comparable coverage.

Requested Effective Date (MM/DD/YYYY):

Requested Contract Renewal Date (MM/DD/YYYY):

Approved Contract Renewal Date (MM/DD/YYYY): (To be completed by Delta Dental)

SECTION 5 — ENROLLMENT OF PLAN BENEFITS

If an employee waives coverage at time of eligibility, the employee will only be able to enroll during your business's annual open enrollment period.

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

If no month is written above, the annual open enrollment changes will be effective the 1st of your renewal month.

How will the initial enrollment choices made by your employees be provided to Delta Dental?

☐ Paper Enrollment Forms
☐ Electronic File (e.g., CSV, Excel, 834 file)

SECTION 6 — MONTHLY RATE INFORMATION

Complete the table below for each of your Delta Dental benefits. All rates must be entered and cannot be left blank.

Coverage Level	Dental Insurance		Vision Insurance	
	# of Employees Enrolled	Monthly Premium Rate	# of Employees Enrolled	Monthly Premium Rate
Employee Only				
Employee + Spouse OR Employee + 1				
Employee + Child(ren)				
Family				

SECTION 7 — PAYMENT OPTIONS

Please select your preferred method for receiving your monthly premium bills. ☐ USPS Mail ☐ Online

*If "Online" is selected, please complete the form titled "Employer Toolkit Authorization Request."

The group policy, enrollee certificate of coverage, and general information on Delta Dental benefits will be sent via email and posted to our Employer Toolkit unless otherwise noted in the "Special Instructions from your business to Delta Dental" section below.

SECTION 8 — THE LEGAL STUFF

Signing this Master Application and Agreement, you hereby acknowledge the following statements from Delta Dental Plan of Arkansas, Inc.

- Eligible dependents will be covered to the end of the month in which they turn 26 years old.
- An employee or dependent's termination date will be the end of the month, unless approved in advance and in writing by Delta Dental.
- You agree to pay as invoiced each month. Self-Billing is not allowed unless approved in advanced and in writing by Delta Dental of Arkansas.

SPECIAL INSTRUCTIONS FROM YOUR BUSINESS TO DELTA DENTAL

On behalf of the business identified above, the undersigned duly authorized representative hereby certifies that the information, terms and provisions in this Master Application and Agreement are complete, true and correct. The undersigned agrees that submission of this Master Application and Agreement 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 Master Application and Agreement. The undersigned further agrees that in making this Application, the business agrees to the terms and provisions of the Group Contract to be provided by Delta Dental of Arkansas (Delta Dental) of which this Master Application and Agreement becomes a part following Delta Dental's decision to provide coverage to the business. The undersigned acknowledges that Delta Dental will consider this information along with the business's experience, enrollment data, and any other applicable information as part of the business's application to Delta Dental for coverage. Coverage or administration for the business will not be effective until the business receives approval in writing from Delta Dental and current coverage should not be cancelled prior to such approval. The business agrees that absence of written approval from Delta Dental does not imply acceptance by Delta Dental. Depending on the plan chosen by the business, 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 business has 15 days from the date of delivery of the Group Contract to return the Group Contract to Delta Dental's corporate headquarters for cancellation of the Group Contract and a full refund. If the business 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 business agrees to issue a refund to Delta Dental or, at Delta Dental's option, Delta Dental will reduce the amount of the refund otherwise payable to the business for all amounts paid by Delta Dental toward these claims. This Master Application and Agreement is subject to approval, refusal, or modification in accordance with Delta Dental's guidelines.

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

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.

Send this completed Master Application and Agreement to:
Delta Dental of Arkansas, Attn: Sales & Account Management, P.O. Box 15965, North Little Rock, AR 72231

A binder check may be required for coverage. If this applies to the plan you have selected, your Delta Dental sales representative will contact you.