



## EMPLOYER GROUP DENTAL CONTRACT MASTER APPLICATION

**Instructions:** 1. Complete this Master Application; 2. Have employees (including waivers) complete enrollment forms; 3. Send the original Master Application, completed enrollment forms, and the initial remittance to Delta Dental of Arizona; 4. Delta Dental will provide an Employer Group Dental Contract upon acceptance of this application; 5. When accepted, this document becomes part of the Employer Group Dental Contract. Fill in blanks and check all items that apply.

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

### Type of Coverage:

\_\_\_\_ Employee Only                      \_\_\_\_ Total Eligible Employees                      Effective Date: \_\_\_\_\_  
\_\_\_\_ Employee & Dependents              \_\_\_\_ Total Waiving Coverage  
\_\_\_\_ Total Enrolling

Type of Industry: \_\_\_\_\_ SIC Code: \_\_\_\_\_

Tax Exempt:    \_\_\_\_ Yes              \_\_\_\_ No

### Eligibility Period:

\_\_\_\_ Date of Hire              \_\_\_\_ 1 Month              \_\_\_\_ 2 Months              \_\_\_\_ 3 Months from date of hire  
First of the Month Following:    \_\_\_\_ 1 Month              \_\_\_\_ 2 Months              \_\_\_\_ 3 Months from date of hire

Other: \_\_\_\_\_

Number of Benefits Eligible Classes (attach a description of criteria for each class): \_\_\_\_\_

Number of Employees in each Class: \_\_\_\_\_ Number of Hours Worked for Full-Time Status: \_\_\_\_\_

Dependent Child(ren) To age: \_\_\_\_\_ Student Status To age: \_\_\_\_\_

Humanitarian Endeavors Included for Dependents \_\_\_\_ Yes \_\_\_\_ No

### Employer Contributions:

For Employee: \_\_\_\_\_ For Dependents: \_\_\_\_\_

\_\_\_\_ This is the contribution that is made toward the INDEMNITY plan.

\_\_\_\_ This is the contribution made toward the pre-paid plan and the employees pay the difference for the indemnity plan.

Does your company currently have a dental plan?              \_\_\_\_ Yes              \_\_\_\_ No

If yes, what type of plan is it?              \_\_\_\_ Indemnity              \_\_\_\_ PPO              \_\_\_\_ Pre-paid

Name of carrier(s): \_\_\_\_\_

(Please also attach a copy of the most recent billing statement)

### Dental Program Benefits:

	<u>Premier or Principle</u>	<u>Voluntary</u>		
Diagnostic and Preventative	____ Percent	____ Percent		
Basic	____ Percent	____ Percent		
Major	____ Percent	____ Percent		
Orthodontics	____ Percent	____ Percent	____ Adult/Child	____ Child Only

### Deductibles:

Annual per Person: \_\_\_\_\_ Per Family: \_\_\_\_\_ Orthodontics Lifetime: \_\_\_\_\_

**Waiting Periods:** \_\_\_\_ Months for Basic              \_\_\_\_ Months for Major              \_\_\_\_ Months for Orthodontics

### Maximums:

Annual per Person: \_\_\_\_\_ Lifetime Orthodontics: \_\_\_\_\_  
Benefit Specific Lifetime Maximum: (ie; TMJ, Periodontics) \_\_\_\_\_ Other: \_\_\_\_\_

**Agent / General Agent of Record (if any)**

Agent Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

\_\_\_\_\_  
(Agent Signature) AZ Insurance Agent License ID Social Security or IRS Number

General Agent Name: \_\_\_\_\_

General Agency Name: \_\_\_\_\_

\_\_\_\_\_  
(Agent Signature) AZ Insurance Agent License ID Social Security or IRS Number

**Quoted Rates:**

**Funding:**

Employee	_____	Pooled	_____	Risk	_____	Retention
Employee and Spouse	_____					
Employee and Child(ren)	_____	ASO	_____	Other	_____	Medical/Dental Lock
Employee and Family	_____					
Composite	_____					

**Participation Requirements:**

<u>Group Size</u>	<u>Required Contribution</u>	<u>Required Participation</u>
10 – 49 Employees	100%	100% of all eligible employees 50% of eligible employees enrolled must insure dependents
50 + Employees	75%	75% of all eligible employees 50% of eligible employees enrolled must insure dependents
Groups who cannot meet listed requirements	50% - 100%	Enrollment must be identical in both the medical and dental plans
Voluntary Plans 10 + Employees	0% - 50%	25% of all eligible employees
Voluntary Plans 3-9 eligible	0%	75% of all eligible employees
Voluntary Plans 3-200 TruVol	0%	Minimum of 3 employees.

Employees may waive coverage should they have coverage through a spouse's Group Dental Plan but there can be no more than 25% of all eligible employees waiving coverage. These waivers will not effect participation requirements.

**Employer Group Policyholder Acknowledgement:**

I attest that the above information is correct and additional information will be provided upon request. The Employer Group Dental Contract applied for hereby shall be effective only after Delta Dental of Arizona (DDAZ) has endorsed its acceptance in the space provided below. The Employer Group and DDAZ will be legally bound to the provisions of the Employer Group Dental Contract with the options and alternatives set forth in this Master Application. The authorized signature by the Employer Group will constitute its acceptance of and agreement to all the terms and conditions of the Employer Group Dental Contract. Any misrepresentation or omission of requested data will cause this Contract, if issued, to be null and void.

\_\_\_\_\_  
Employer Group (Applicant's name - Please Print)

\_\_\_\_\_  
Signer's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signer's Title (Please Print)