DELTA DENTAL®

# Employer Group Implementation Requirements: 10+ Enrolled Employees

Thank you for choosing Delta Dental of Arizona. Please see the checklist below for the items required for implementation of your new group. All enrollment materials may be emailed to your implementation specialist and must be received by the group's effective date.

## Employer Group Enrollment

Please complete the following documents:

☐ **Employer Group Master Application: 10+ Enrolled Employees** (Completed & signed)

☐ **Prior Carrier Coverage** (If applicable)

Please provide a copy of the prior carrier's benefits or a copy of last billing statement.

## Billing

Please select one of the following options:

☐ **ACH Form** (Completed & signed)

ACH is available for dental and vision. Billing notifications are emailed to the billing contact on file and invoices can be downloaded from the Benefit Manager Toolkit. If applicable, the group will elect to receive either a consolidated invoice for both dental and vision or separate invoices for dental and vision. This election is to be made on the master application at time of group submission. The first month's premium check is not required.

☐ **Check**

Billing notifications are sent to the billing contact on file and invoices can be downloaded from the Benefit Manager Toolkit. If applicable, the group will elect to receive either a consolidated invoice for both dental and vision or separate invoices for dental and vision. This election is to be made on the master application at time of group submission. Check payments should reflect the total due on the invoice and be sent to the remittance address on the invoice. If sending a single check for dental and vision premiums, include the remittance slips for both invoices. The first month's premium check is not required for implementation.

## Employee Enrollment

Please select one of the following options:

☐ **Employee Enrollment Application** (Completed & signed)

Employees enrolling coverage should complete Sections A, B, C, E. Employee must sign Section E. Employer must complete Section F.

Employees declining coverage should complete sections A, B, D, E. Employee must sign Section E. Employer must complete Section F.

☐ **Enrollment Spreadsheet**

Spreadsheet must match Delta Dental of Arizona's standard format.

☐ **834 Enrollment File**

Please contact Delta Dental of Arizona for more information on this option.

## Benefit Manager Toolkit Access

The Benefit Manager Toolkit (BMT) is a secure, online portal for group administration and billing. Each group has a designated BMT administrator who controls additional user access and permissions. The BMT administrator should keep an eye out for an email from donotreply@mydeltadental.com with the subject line "Benefit Manager Toolkit Client Registration." The email will include a link to the registration page and an access code.

(Please note that enrollment and eligibility updates submitted via an 834 enrollment file will override any updates submitted through BMT.)

**For onboarding a new client or implementation assistance, please email: implementation@deltadentalaz.com**

Please feel free to contact us with any questions.


**Jaquel Hodge**
Implementation Specialist
Direct 602.588.3637
Toll-Free 800.352.6132 ext. 3637
Fax 602.588.3637
Email jhodge@deltadentalaz.com

**Tammra Laurent**
Implementation Specialist
Direct 602.588.3937
Toll-Free 800.352.6132 ext. 3937
Fax 602.588.3937
Email tlaurent@deltadentalaz.com

DELTA DENTAL®

# Employer Group Master App: 10+ Enrolled Employees

Thank you for choosing Delta Dental. This Employer Group Master App may be used to apply for a variety of dental and vision programs offered by Delta Dental. The PPO dental plan and vision plan are underwritten and/or administered by Delta Dental of Arizona (DDAZ). This combined application is being used for your convenience only. Each plan is separately underwritten, administered and serviced.

## SECTION A: General Information

| | | | |
|---|---|---|---|
| Company Name | | | |
| Address | | | |
| City | County | State | Zip |
| Email | Business Phone | | |
| TIN | NAICS # | | |
| Type of Industry | SIC Code | | |

## SECTION B: Eligibility and Enrollment

| | | |
|---|---|---|
| Eligibility Contact Name | Eligibility Contact Email | Eligibility Contact Phone |

**Dependent child(ren) to age:** _____

**Student status up to age:** _____

**Domestic partner coverage?** ☐ Yes ☐ No

**Waive eligibility period on initial enrollees?** ☐ Yes ☐ No

**New hire waiting period:**
- ☐ 1st of the month following _____
- ☐ Date of hire

**Qualifying events are effective:**
- ☐ 1st of the month following event (DDAZ standard)
- ☐ Date of event

**Member Termination:**
- ☐ End of month (DDAZ standard)
- ☐ Date of termination

**How will we receive initial enrollment?**
- ☐ Enrollment Spreadsheet (Must follow DDAZ standard format)
- ☐ Enrollment Forms
- ☐ Electronic File Feed

**How will we receive ongoing enrollment?**
- ☐ Benefit Manager Toolkit (portal)
- ☐ Enrollment Forms
- ☐ Electronic File Feed

**Would the group like to receive an overage dependent report?** If yes, the report will be available in the Benefit Manager Toolkit.
- ☐ Yes
- ☐ No

## SECTION C: Dental/Vision Billing

**Is the contact the same as the eligibility contact listed in section B?** ☐ Yes ☐ No

| | | |
|---|---|---|
| Billing Contact Name | Billing Contact Email | Billing Contact Phone |

**Monthly payment method:** ☐ ACH credit ☐ ACH debit (Required for ASO) ☐ Check

**Billing notification delivery method:** ■ Email

**Do you want consolidated billing for dental and vision, if applicable?** ☐ Yes ☐ No

**Apply consolidated billing to all billing divisions?** ☐ Yes ☐ No

## SECTION D: Dental/Vision COBRA

**Is the contact the same as the eligibility contact listed in section B?** ☐ Yes ☐ No

| | | |
|---|---|---|
| COBRA Contact Name | COBRA Contact Email | COBRA Contact Phone |
| COBRA Vendor | | |

**How will we receive COBRA enrollment?**
- ☐ Benefit Manager Toolkit (portal)
- ☐ Enrollment Forms
- ☐ Electronic File Feed
- ☐ Excel Spreadsheet (Follow PPO standard file layout.)

FORM CONTINUES TO NEXT PAGE.

## SECTION E: Current Dental Plan Information (Please attach a copy of the most recent billing statement or benefit summary.)

**Does your company currently have a dental plan?** ☐ Yes ☐ No

**If yes, what type of plan is it?** ☐ Indemnity ☐ PPO ☐ Pre-paid **Effective Date:** _____/_____/_____ (MM/DD/YYYY)

| Name of Carrier(s) | Reason for Change |
|---|---|
| | |

## SECTION F: Current Vision Plan Information (Please attach a copy of the most recent billing statement or benefit summary.)

**Does your company currently have a vision plan?** ☐ Yes ☐ No

| Name of Carrier(s) | Reason for Change |
|---|---|
| | |

## SECTION G: Dental Employer Contributions and Participation

**Total number of eligible employees:** _____
**Total number waiving with other coverage:** _____
**Total number waiving without other coverage:** _____
**Total number enrolling:** _____

**Effective Date:** _____/_____/_____ (MM/DD/YYYY)

**Contributions:** For Employee: _____% For Dependents: _____%

**Contract Term:** _____/_____/_____ (MM/DD/YYYY) to _____/_____/_____ (MM/DD/YYYY)

## SECTION H: Dental Plan Selection (Selections must match dental quote. Please attach original quote for processing.)

**CO-INSURANCE** (Enter percentage)

**Select your plan:** ☐ Delta Dental PPO™ ☐ Delta Dental PPO Plus Premier™

| | |
|---|---|
| Routine Services | % |
| Basic Services | % |
| Major Services | % |
| Orthodontics | % |

**ORTHODONTIC COVERAGE** (Check one)

☐ Yes - Adult/Child
☐ Yes - Child Only
☐ No

| Calendar Year Deductible: | Benefit Waiting Periods: | Benefit Maximums: |
|---|---|---|
| $ _____ per person | Major _____ months | Calendar Year $ _____ |
| $ _____ per family | Orthodontics _____ months | Orthodontics Lifetime $ _____ |

**Quoted Rates/ASO Fees:** ☐ Two-tier ☐ Three-tier ☐ Four-tier ☐ Composite

**Funding Type:** ☐ Pooled ☐ Risk ☐ ASO

**RATES**

| | |
|---|---|
| Employee only | $ _____ |
| Employee + spouse (employee + one dependent) | $ _____ |
| Employee + children (employee + two dependents) | $ _____ |
| Employee + family | $ _____ |

**FORM CONTINUES TO NEXT PAGE.**

## SECTION H.1: Second Dental Plan Selection — if applicable

(Selections must match dental quote. Please attach original quote for processing.)

**CO-INSURANCE** (Enter percentage)

| Select your plan ☐ Delta Dental PPO™ ☐ Delta Dental PPO Plus Premier™ | |
|---|---|
| Routine Services | % |
| Basic Services | % |
| Major Services | % |
| Orthodontics | % |

**ORTHODONTIC COVERAGE** (Check one)

- ☐ Yes - Adult/Child
- ☐ Yes - Child Only
- ☐ No

| Calendar Year Deductible: | Benefit Waiting Periods: | Benefit Maximums: |
|---|---|---|
| $ _____ per person | Major _____ months | Calendar Year $ _____ |
| $ _____ per family | Orthodontics _____ months | Orthodontics Lifetime $ _____ |

**Quoted Rates/ASO Fees:** ☐ Two-tier ☐ Three-tier ☐ Four-tier ☐ Composite

**Funding Type:** ☐ Pooled ☐ Risk ☐ ASO

**RATES**

| | |
|---|---|
| Employee only | $ _____ |
| Employee + spouse (employee + one dependent) | $ _____ |
| Employee + children (employee + two dependents) | $ _____ |
| Employee + family | $ _____ |

## SECTION H.2: Third Dental Plan Selection — if applicable

(Selections must match dental quote. Please attach original quote for processing.)

**CO-INSURANCE** (Enter percentage)

| Select your plan ☐ Delta Dental PPO™ ☐ Delta Dental PPO Plus Premier™ | |
|---|---|
| Routine Services | % |
| Basic Services | % |
| Major Services | % |
| Orthodontics | % |

**ORTHODONTIC COVERAGE** (Check one)

- ☐ Yes - Adult/Child
- ☐ Yes - Child Only
- ☐ No

| Calendar Year Deductible: | Benefit Waiting Periods: | Benefit Maximums: |
|---|---|---|
| $ _____ per person | Major _____ months | Calendar Year $ _____ |
| $ _____ per family | Orthodontics _____ months | Orthodontics Lifetime $ _____ |

**Quoted Rates/ASO Fees:** ☐ Two-tier ☐ Three-tier ☐ Four-tier ☐ Composite

**Funding Type:** ☐ Pooled ☐ Risk ☐ ASO

**RATES**

| | |
|---|---|
| Employee only | $ _____ |
| Employee + spouse (employee + one dependent) | $ _____ |
| Employee + children (employee + two dependents) | $ _____ |
| Employee + family | $ _____ |

**FORM CONTINUES TO NEXT PAGE.**

## SECTION I: Vision Employer Contributions and Participation

**Total number of eligible employees:** _____

**Total number enrolling:** _____

**Effective Date:** _____/_____/_____ (MM/DD/YYYY)

**Contributions:** For Employee: _____% For Dependents: _____%

**Contract Term:** _____/_____/_____ (MM/DD/YYYY) to _____/_____/_____ (MM/DD/YYYY)

## SECTION J: Vision Plan Selection (Selections must match vision quote. Please attach original quote for processing.)

**Plan Number:** _____

**Quoted Rates:** ☐ Two-tier ☐ Three-tier ☐ Four-tier

### RATES

| | |
|---|---|
| Employee only | $ _____ |
| Employee + spouse (employee + one dependent) | $ _____ |
| Employee + children (employee + two dependents) | $ _____ |
| Employee + family | $ _____ |

### ADDITIONAL PLAN FEATURES

☐ One & Sun™

## SECTION K: Benefit Manager Toolkit Access for Dental and Vision Administration

**Group Admin Access to Electronic Data**

The Benefit Manager Toolkit (BMT) is Delta Dental of Arizona's secure portal for online enrollment and billing services. Each group must designate a BMT administrator who controls additional user access and permissions.

| | |
|---|---|
| BMT Admin Name | BMT Admin Title |
| BMT Admin Email | BMT Admin Phone |

**Agent Access to Electronic Data**

Agent shall/shall not have electronic data access via Delta Dental of Arizona's secure portal. By granting access to Agent, Group is allowing the Agent to potentially make enrollment changes on its behalf. If Agent is granted access, it is the Group's responsibility to notify Delta Dental of Arizona to remove online access.

☐ Accept ☐ Decline

| | |
|---|---|
| Agent Name | Agent Email |
| Agent Name | Agent Email |
| Agent Name | Agent Email |

FORM CONTINUES TO NEXT PAGE.

## SECTION L: Agent/General Agent of Record

| | | | |
|---|---|---|---|
| Agent Name | | | |
| Agency Name | | | |
| Address | | | |
| City | State | Zip | Email |
| Phone | | Fax | |

**Does your agency operate under your Social Security Number or Tax ID Number?**

☐ Social Security Number: _____ ☐ Tax ID Number: _____

| | | |
|---|---|---|
| _____ Agent Signature | _____ National Producer Number (Agent) | _____ National Producer Number (Agency) |

| | |
|---|---|
| General Agent Name | General Agency Name |

**Does your general agency operate under your Social Security Number or Tax ID Number?**

☐ Social Security Number: _____ ☐ Tax ID Number: _____

| | | |
|---|---|---|
| _____ General Agent Signature | _____ National Producer Number (Agent) | _____ National Producer Number (Agency) |

## SECTION M: Employer Group Authorization to Share Protected Health Information

By signing below, I hereby authorize Delta Dental of Arizona to share, exchange, transmit and receive the Group's member Protected Health Information (PHI) with the following file vendor, agent/broker, and/or third party.

| | |
|---|---|
| File Vendor Name | |
| Agent/Broker Name | Other Third Party Name |
| _____ Signature | _____/_____/_____ Date Signed (MM/DD/YYYY) |

## SECTION N: Employer Group Policyholder Acknowledgement

I attest that the above information is correct and agree to provide additional information upon request. The Policy applied for hereby shall be effective upon underwriting approval and the issuance of a group number. The Policyholder and Delta Dental of Arizona will be legally bound to the provisions of the Policy with the options and alternatives set forth in this Master Application. Any misrepresentation or omission of requested data will cause the Policy, if issued, to be null and void.

| | |
|---|---|
| Employer Group Name | |
| _____ Signature | _____/_____/_____ Date Signed (MM/DD/YYYY) |
| Authorized Signer's Name | Authorized Signer's Title |
| Email (For future communications regarding this application) | |

DELTA DENTAL®

# Electronic Funds Transfer (EFT) Authorization: Group Dental/Vision Plans

EFT AUTHORIZATION AGREEMENT FOR PREMIUM PAYMENTS

I (we) hereby authorize Arizona Dental Insurance Service Inc., dba Delta Dental of Arizona, to initiate debit (withdrawal) entries and to initiate, if necessary, credit entries and adjustments for any debit (withdrawal) entries in error to my account and the financial institution indicated below:

| **Group Information** | |
|---|---|
| Group Name | |
| Federal Tax ID Number | Group Number |
| Group Contact Name | Group Contact Phone Number |
| Email of Contact to Receive EFT Statement | |

| **Bank Information** | |
|---|---|
| Name of Financial Institution | Account Name (If applicable) |
| Contact Person (If applicable) | Contact Phone Number |
| Bank Routing Number | |
| Account Number (Checking) | ☐ Savings ☐ Checking |

*Delta Dental of Arizona will keep all financial information secure and confidential*

| **Authorization** | |
|---|---|
| Name | Name |
| _____ Authorized Signature _____/_____/_____ Date | _____ Authorized Signature _____/_____/_____ Date |

This authorization is to remain in full force and effect until Delta Dental of Arizona and said financial institution have received written notification from me of its termination in such time and in such manner to afford Delta Dental of Arizona and said financial institution a reasonable opportunity to act upon it.

I understand that any EFT transactions that are dishonored by my financial institution may be assessed a $25 service charge.

**Submission**
Please email, fax, and or mail the completed application and EFT authorization to:

Delta Dental of Arizona
14850 N. Scottsdale Rd.
Scottsdale, Suite 400, AZ 85254
Email: billing@deltadentalaz.com
Fax: 602.548.5071

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| SECTION F: Employer Use Only | |
|---|---|
| **Employer Name:** _____ | **Group Number:** _____ |
| **Effective 1st Day Of:** _____/_____ (MM/YYYY) | **Subgroup Number:** _____ |

# Enrollment Application/Change of Status Form

Instructions on reverse side.

## SECTION A: Qualifying Event

☐ **NEW HIRE** (Complete sections B, C, D, E)
☐ **OPEN ENROLLMENT** (Complete sections B, C, D, E)
☐ Dental
Plan:
☐ Premier
☐ PPO plus Premier
☐ PPO
☐ enhanced Premier
Option:
☐ High/Buy-up
☐ Medium
☐ Low/Base
☐ Vision

☐ **DECLINE COVERAGE** (Complete sections B, D, E)
☐ Dental ☐ Vision

☐ **CHANGE OF STATUS** (Complete sections B, C, D, E)
☐ Dental ☐ Vision

☐ Cancel Coverage (Complete section B, E) ☐ COBRA (Complete sections B, C, D, E)

☐ Address Change (Complete section B, E)

☐ Name Change To: _____ From: _____

☐ Add/Delete Dependent(s) (Complete sections B, C, E)
☐ Marriage ☐ Birth ☐ Retire
☐ Divorce ☐ Adoption ☐ Loss of Coverage ☐ Other - Reason: _____

## SECTION B: Employee Information

| Social Security Number | Employer Name | | |
|---|---|---|---|
| Employee's Last Name | First | MI | Marital Status ☐ Single ☐ Married |
| Home Address (Mailing) | | | Gender ☐ M ☐ F ☐ U |
| | | | Date of Birth ____/____/____ (MM DD YYYY) |
| City | State | Zip | Email |

## SECTION C: Dependent Information

| Add | Change | Delete | Last Name (If different), First, MI | Dental | Vision | Relationship to Employee | Gender M/F/U | Social Security Number | Date of Birth | Full-Time Student Y/N | Disabled Y/N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | | ☐ | ☐ | | | | ____/____/____ MM DD YYYY | | |
| ☐ | ☐ | ☐ | | ☐ | ☐ | | | | ____/____/____ MM DD YYYY | | |
| ☐ | ☐ | ☐ | | ☐ | ☐ | | | | ____/____/____ MM DD YYYY | | |
| ☐ | ☐ | ☐ | | ☐ | ☐ | | | | ____/____/____ MM DD YYYY | | |

## SECTION D: Other Coverage Information

Do you or any member of your family have coverage under another group dental insurance plan?
☐ YES – Please check the appropriate box(es) and complete Section D ☐ NO – Please skip to Section E
☐ Medical ☐ Dental ☐ COBRA ☐ Retiree ☐ Vision

| Insurance Company Name | Effective Date of Coverage _____/_____/_____ (MM/DD/YYYY) |
|---|---|
| Name of Policyholder | Policyholder's Date of Birth _____/_____/_____ (MM/DD/YYYY) |

Please indicate to whom this coverage applies (Check all that apply). ☐ Self ☐ Spouse ☐ All Children ☐ Child(ren) _____ Name(s)

| Name of Dependent | Relationship to Policyholder |
|---|---|
| | |
| | |
| | |

## SECTION E: Authorization

I hereby apply for coverage with Delta Dental of Arizona pursuant to the terms specified on the reverse side of this form, which are hereby incorporated by reference.

_____ Employee's Signature/Authorization
_____ Date Signed (MM/DD/YYYY)
_____ Employer's Signature/Authorization
_____ Date Signed (MM/DD/YYYY)

DDAZ-0002-rev0225

I apply for benefits with Delta Dental of Arizona (Delta Dental), and on behalf of any dependents and myself, I agree to be bound by the provisions of my dental or vision plan (the Plan). If accepted, this application, the identification card and the group contract will constitute the Plan.

I understand and agree that my coverage and that of any dependents will become effective on the date established by my employer in Section F. Any dependents that are added to my Plan later will have different effective dates.

My employer or group administrator is authorized to deduct my share of dental premiums, if any, from my wages for 12 months and during any renewal periods. My employer or group administrator is authorized to remit a premium to Delta Dental and to receive all notices from Delta Dental relating to my coverage. I understand that enrollment is for consecutive 12-month period, and my contribution is subject to change on renewal. Further, I understand that non-compliance with these terms voids any benefits during an enrollment period.

I will notify Delta Dental upon any change that would make me or any dependent ineligible for coverage.

I will cooperate with Delta Dental and furnish all information requested to enforce Delta Dental's right to coordinate benefits.

I understand that Delta Dental may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. If false or misleading information is discovered, Delta Dental may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application. Any claims paid during the periods when the coverage was not in force will be deducted from the premium refund. If the benefits paid by Delta Dental exceeds the premium paid, I agree to refund any excess amount to Delta Dental.

By providing my email address, I agree that Delta Dental of Arizona and/or third-party vendors acting on its behalf may send me emails containing information related to health and wellness, my coverage or the services I receive.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement is guilty of insurance fraud. By signing above, I certify, under the penalties of law, that the information submitted on this form is accurate and complete.

Uses and Disclosures of Health Information: At Delta Dental, we use health information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. For more information about our privacy practices, please visit www.deltadentalaz.com under privacy policy or contact Customer Service, Phone: 602.938.3131 or 800.352.6132, Email: customerservice@deltadentalaz.com.

# Instructions

### SECTION A - Determine the Qualifying Event

Please check or complete all boxes that indicate whether you are a new enrollee or you are requesting an update to your current coverage. If you are requesting a coverage update, select the appropriate qualifying event and indicate the date of the event.

**New Hire/Open Enrollment:** Select the dental plan offered by your employer. If vision is being offered and you would like to apply for coverage, please check the vision box. Please complete Sections B, C, D, and E.

**Decline Coverage:** If you would like to decline dental or vision coverage, please check the dental and/or vision option. Please complete sections B, D, and E.

**Change of Status:**

- **Cancel Coverage** - Check the Cancel Coverage box and complete sections B and E.
- **COBRA** - Check the COBRA box and complete sections B, C, D, and E.
- **Address Change** - Check the address change box and complete section B and E.
- **Add/Delete Dependent(s)** - Please indicate the qualifying event add the date of the event. Please complete sections B, C, and E.

### SECTION B - Employee Information

Please complete this section in its entirety for all circumstances.

### SECTION C - Dependent Information

Check either add, change or delete to select the appropriate dependent action. Complete dependent information and select the dental or vision option to apply for coverage or to make the selected updates.

### SECTION D - Other Coverage Information

Complete this section if you or any of your dependents have additional dental coverage that will not be cancelled when this plan becomes effective.

### SECTION E - Authorization

Once you have completed the appropriate sections and reviewed the terms above, please sign and date this form.
*Employer: Sign and date this form before submitting to Delta Dental of Arizona.*

### SECTION F - Employer Use Only

Submit the signed form to your employer, who will complete section F.
*Employer: Complete section F before submitting to Delta Dental of Arizona.*