DELTA DENTAL

Employer Group Implementation Requirements: 2-9 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: 2-9 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 complete the following document:

- ☐ **ACH Form** (Completed & signed)**:** ACH is required 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 for implementation.

Employee Enrollment

Please select <u>one</u> of the following options:

- ☐ **Employee Enrollment Application/Change of Status Form or Coverage Waiver Form** (Completed & signed)

  Employees enrolling in coverage must complete Sections A, B, C, E. Employee must sign Section E. Employer must also complete Section F.
  Employees declining coverage should complete sections A, B, D, E. Employee must sign Section E. Employer must complete Section F.

  (Please note that all future enrollments and eligibility updates will need to be submitted through the Benefit Manager Toolkit.)

- ☐ **Enrollment Spreadsheet**

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

  (Please note that all future enrollments and eligibility updates will need to be submitted through the Benefit Manager Toolkit.)

- ☐ **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 additional questions.

Jaquel Hodge
Implementation Specialist
Direct 602.588.3637
Toll-Free 800.352.6132 ext. 3637
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DELTA DENTAL®

Employer Group Master App: 2-9 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: 26

Waive eligibility period on initial enrollees? ☐ Yes ☐ No

Domestic partner coverage? ☐ Yes ☐ No

New hire waiting period:
- ■ 1st of the month following _____

Qualifying events are effective:
- ■ 1st of the month following event

Member Termination:
- ■ End of month

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)
- ☐ 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 debit (Required for 2-9)

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
- ☐ Enrollment Spreadsheet (Must follow DDAZ standard format)

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 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:

	☐ Option 1: MAC PPO
☐ Option 2 Lite: MAC PPO	☐ Option 2: MAC PPO
☐ Option 3 Lite: PPO Plus Premier	☐ Option 3: PPO Plus Premier
☐ Option 4 Lite: MAC PPO	☐ Option 4: MAC PPO
☐ Option 5 Lite: PPO plus Premier	☐ Option 5: PPO plus Premier
☐ Option 8 Lite: MAC PPO	☐ Option 8: MAC PPO
☐ Option 9 Lite: PPO plus Premier	☐ Option 9: PPO plus Premier

Routine Services	%
Basic Services	%
Major Services	%
Orthodontics	%

ADDITIONAL PLAN FEATURES (Check all that apply)

- ☐ CheckUp Plus™
- ☐ Composite Fillings
- ☐ Orthodontics (Child only)

Calendar Year Deductible:	Benefit Waiting Periods:	Benefit Maximums:
$ ____$50____ per person	Major _____0_____ months	Calendar Year $ _____
$ ____$150____ per family	Orthodontics _____6_____ months if no prior coverage	Orthodontics Lifetime $ _____

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

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

Select your plan:

- ☐ Diamond
- ☐ Platinum
- ☐ Gold
- ☐ Silver
- ☐ Bronze

ADDITIONAL PLAN FEATURES

- ☐ One & Sun™

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

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

SECTION K: Benefit Manager Toolkit 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

DELTA DENTAL®

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.