

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. 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: <u>26</u>		Waive eligibility period on initial enrollees? <input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic partner coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
New hire waiting period: <input checked="" type="checkbox"/> 1st of the month following _____	Qualifying events are effective: <input checked="" type="checkbox"/> 1st of the month following event	Member Termination: <input checked="" type="checkbox"/> End of month
How will we receive <u>initial</u> enrollment? <input type="checkbox"/> Enrollment spreadsheet (Must follow DDAZ standard format) <input type="checkbox"/> Enrollment Forms <input type="checkbox"/> Electronic File Feed	How will we receive <u>ongoing</u> enrollment? <input type="checkbox"/> Benefit Manager Toolkit (portal) <input type="checkbox"/> Electronic File Feed	Would the group like to receive an <u>average dependent report</u>? If yes, the report will be available in the Benefit Manager Toolkit. <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION C: Dental/Vision Billing		
Is the contact the same as the eligibility contact listed in section B? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Billing Contact Name	Billing Contact Email	Billing Contact Phone
Monthly payment method: <input checked="" type="checkbox"/> ACH debit (Required for 2-9)	Billing notification delivery method: <input checked="" type="checkbox"/> Email	
Do you want consolidated billing for dental and vision, if applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Apply consolidated billing to all billing divisions? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION D: Dental/Vision COBRA		
Is the contact the same as the eligibility contact listed in section B? <input type="checkbox"/> Yes <input type="checkbox"/> No		
COBRA Contact Name	COBRA Contact Email	COBRA Contact Phone
COBRA Vendor		
How will we receive COBRA enrollment? <input type="checkbox"/> Benefit Manager Toolkit (portal) <input type="checkbox"/> Enrollment Forms <input type="checkbox"/> 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: ____/____/____ to ____/____/____ (MM/DD/YYYY)

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

<p>CO-INSURANCE (Enter percentage)</p> <p>Select your plan:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> Option 1: MAC PPO</td> <td><input type="checkbox"/> Option 2: MAC PPO</td> </tr> <tr> <td><input type="checkbox"/> Option 2 Lite: MAC PPO</td> <td><input type="checkbox"/> Option 3: PPO Plus Premier</td> </tr> <tr> <td><input type="checkbox"/> Option 3 Lite: PPO Plus Premier</td> <td><input type="checkbox"/> Option 4: MAC PPO</td> </tr> <tr> <td><input type="checkbox"/> Option 4 Lite: MAC PPO</td> <td><input type="checkbox"/> Option 5: PPO plus Premier</td> </tr> <tr> <td><input type="checkbox"/> Option 5 Lite: PPO plus Premier</td> <td><input type="checkbox"/> Option 8: MAC PPO</td> </tr> <tr> <td><input type="checkbox"/> Option 8 Lite: MAC PPO</td> <td><input type="checkbox"/> Option 9: PPO plus Premier</td> </tr> <tr> <td><input type="checkbox"/> Option 9 Lite: PPO plus Premier</td> <td></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td>Routine Services</td> <td style="text-align:right">%</td> </tr> <tr> <td>Basic Services</td> <td style="text-align:right">%</td> </tr> <tr> <td>Major Services</td> <td style="text-align:right">%</td> </tr> <tr> <td>Orthodontics</td> <td style="text-align:right">%</td> </tr> </table>	<input type="checkbox"/> Option 1: MAC PPO	<input type="checkbox"/> Option 2: MAC PPO	<input type="checkbox"/> Option 2 Lite: MAC PPO	<input type="checkbox"/> Option 3: PPO Plus Premier	<input type="checkbox"/> Option 3 Lite: PPO Plus Premier	<input type="checkbox"/> Option 4: MAC PPO	<input type="checkbox"/> Option 4 Lite: MAC PPO	<input type="checkbox"/> Option 5: PPO plus Premier	<input type="checkbox"/> Option 5 Lite: PPO plus Premier	<input type="checkbox"/> Option 8: MAC PPO	<input type="checkbox"/> Option 8 Lite: MAC PPO	<input type="checkbox"/> Option 9: PPO plus Premier	<input type="checkbox"/> Option 9 Lite: PPO plus Premier		Routine Services	%	Basic Services	%	Major Services	%	Orthodontics	%	<p>ADDITIONAL PLAN FEATURES (Check all that apply)</p> <table border="1" style="width:100%"> <tr> <td> <input type="checkbox"/> CheckUp Plus™ <input type="checkbox"/> Composite Fillings <input type="checkbox"/> Orthodontics (Child only) </td> </tr> </table>	<input type="checkbox"/> CheckUp Plus™ <input type="checkbox"/> Composite Fillings <input type="checkbox"/> Orthodontics (Child only)
<input type="checkbox"/> Option 1: MAC PPO	<input type="checkbox"/> Option 2: MAC PPO																							
<input type="checkbox"/> Option 2 Lite: MAC PPO	<input type="checkbox"/> Option 3: PPO Plus Premier																							
<input type="checkbox"/> Option 3 Lite: PPO Plus Premier	<input type="checkbox"/> Option 4: MAC PPO																							
<input type="checkbox"/> Option 4 Lite: MAC PPO	<input type="checkbox"/> Option 5: PPO plus Premier																							
<input type="checkbox"/> Option 5 Lite: PPO plus Premier	<input type="checkbox"/> Option 8: MAC PPO																							
<input type="checkbox"/> Option 8 Lite: MAC PPO	<input type="checkbox"/> Option 9: PPO plus Premier																							
<input type="checkbox"/> Option 9 Lite: PPO plus Premier																								
Routine Services	%																							
Basic Services	%																							
Major Services	%																							
Orthodontics	%																							
<input type="checkbox"/> CheckUp Plus™ <input type="checkbox"/> Composite Fillings <input type="checkbox"/> 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: ____/____/____ to ____/____/____ (MM/DD/YYYY) (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	ADDITIONAL PLAN FEATURES
Employee only	<input type="checkbox"/> One & Sun™
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

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 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 OF ARIZONA GROUP HEALTH PLAN AUTHORIZATION

Group and Plan Sponsor, acting for and on behalf of its group health plan (“Plan”) purchased group dental benefits and/or vision benefits, and/or other ancillary insurance or benefit contracts (together hereinafter the “Benefits”) from Delta Dental of Arizona and/or its affiliates whether acting as insurer, producer, or administrator (“DDAZ”). Certain of the Benefits may involve the exchange of Protected Health Information and Electronic Protected Health Information as defined in 45 C.F.R. § 160.103 (“PHI”) with DDAZ as defined below. In order to facilitate the exchange of PHI (and non-PHI) in connection with those Benefits between DDAZ and the Plan, subject to any applicable federal and state privacy laws, Group and Plan Sponsor acting for and on behalf of its Plan hereby authorizes the disclosure, transmission, receipt and exchange of PHI by, between and among DDAZ and the Plan, the Plan’s third-party administrator (“Plan Admin”), and its producer, broker and/or agent (“Broker”) including with, through and over a benefit enrollment services platform (“Platform”) utilized by Broker, Plan, Plan Admin, and DDAZ.

For any confidential and/or sensitive information that is not deemed PHI (such as employer record information that may be required for enrollment, disenrollment or eligibility purposes with respect to the Benefits) as well as the disclosure of limited categories of PHI that may be shared with Group and Plan Sponsor without an individual’s authorization (such as Summary Health Information of the participants as defined in 45 C.F.R. § 164.504(a) for the purposes of underwriting, brokering, and obtaining premium bids for the purposes of quoting on or renewing Benefits, or for modifying, amending or terminating any of the Benefits), subject to any applicable federal and state privacy laws, Group and Plan Sponsor acting for and on behalf of its Plan hereby authorize the disclosure, transmission, receipt and exchange by, between and among DDAZ and the Plan, the Plan Admin, and Broker including with, through and over Platform utilized by Broker, Plan, Plan Admin, and DDAZ.

Additionally, Group and Plan Sponsor agree as follows:

Group and Plan Sponsor are responsible for compliance with relevant state/federal law if a breach of PHI occurs related to plan functions performed by Group and Plan Sponsor.

Group and Plan Sponsor agree that any request it makes for the disclosure of PHI will comply with the minimum necessary standard as set for at 45 C.F.R. 164.502(b) and 164.514(d) and that DDAZ has no obligation to make a separate determination of whether the information accessed or requested by Group and Plan Sponsor satisfies HIPAA’s minimum necessary standard.

Group and Plan Sponsor agree that any request for DDAZ to make available claims data will be used by plan sponsor employees for plan administration functions consistent with 45 CFR 164.504(f)(2) and 164.314(b) and that DDAZ has no obligation to make a separate determination of whether the information accessed or requested by Group and Plan Sponsor qualifies as a plan administration function.

1. Designation of Broker and TPA

This Authorization is effective for the Plan, Plan Admin and Broker named on this form.

If the Broker listed on this form is, at any time, different from the broker listed on a Broker of Record form (“BOR form”) properly filed with DDAZ, then Group and Plan Sponsor instruct DDAZ that Broker for purposes of this authorization will be the broker designated on the most current BOR form filed with DDAZ.

Should the Group and Plan Sponsor’s designated Broker or third party administrator change, the Group and Plan Sponsor is required to update their authorization so that DDAZ may continue to share information.

Group Name: _____ DDAZ Group Number: _____

Designated Broker: _____ Broker NPN: _____

General Agency: _____ GA Broker NPN: _____

Designated Third Party Administrator: (Provide active/COBRA file feed vendor details below)

Active Feed TPA Company: _____

Address: _____

COBRA TPA Company: _____

Address: _____

2. Expiration of Authorization

This Authorization will expire immediately following the completion of DDAZ’s services with respect to a terminated Benefit, however, it will continue with respect to any continuing services and Benefits provided by DDAZ. Additionally, this authorization will expire upon DDAZ’s receipt of Group and Plan Sponsor’s written request to terminate this Authorization.

3. Certification

Group and Plan Sponsor certifies that the employee signing below on behalf of the Group and Plan Sponsor has read and understands this Authorization form and has authority to sign and bind Group and Plan Sponsor to the terms set forth herein.

Group and Plan Sponsor Name: _____

Signature: _____

Name: _____

Title: _____

Date: _____



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)	<input type="checkbox"/> Savings <input type="checkbox"/> Checking

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

Authorization	
Name	Name
<hr/> Authorized Signature / / Date	<hr/> 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., Suite 400
Scottsdale, AZ 85254
Email: billing@deltadentalaz.com
Fax: 602.548.5071



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)
DECLINE COVERAGE (Complete sections B, D, E)
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
Home Address (Mailing)
City State Zip Email
Marital Status Single Married
Gender M F U
Date of Birth ____/____/____ (MM/DD/YYYY)

SECTION C: Dependent Information

Table with 12 columns: 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

SECTION D: Other Coverage Information

Do you or any member of your family have coverage under another group dental insurance plan?
Insurance Company Name Effective Date of Coverage
Name of Policyholder Policyholder's Date of Birth
Please indicate to whom this coverage applies (Check all that apply). Self Spouse All Children Child(ren)
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.