

# 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 one 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](mailto:implementation@deltadentalaz.com)**

Please feel free to contact us with any additional questions.

<b>Jaquel Jones</b>	Direct	602.588.3637
Implementation Specialist	Toll-Free	800.352.6132 ext. 3637
	Fax	602.588.3637
	Email	<a href="mailto:jjones@deltadentalaz.com">jjones@deltadentalaz.com</a>

<b>Tammra Laurent</b>	Direct	602.588.3937
Implementation Specialist	Toll-Free	800.352.6132 ext. 3937
	Fax	602.588.3937
	Email	<a href="mailto:tlaurent@deltadentalaz.com">tlaurent@deltadentalaz.com</a>

# 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: <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		
<b>New hire waiting period:</b> <input checked="" type="checkbox"/> 1st of the month following _____	<b>Qualifying events are effective:</b> <input checked="" type="checkbox"/> 1st of the month following event	<b>Member Termination:</b> <input checked="" type="checkbox"/> End of month
<b>How will we receive initial enrollment?</b> <input type="checkbox"/> Enrollment spreadsheet (Must follow DDAZ standard format) <input type="checkbox"/> Enrollment Forms <input type="checkbox"/> Electronic File Feed	<b>How will we receive ongoing enrollment?</b> <input type="checkbox"/> Benefit Manager Toolkit (portal) <input type="checkbox"/> Electronic File Feed	<b>Would the group like to receive an average dependent report?</b> 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
<b>Monthly payment method:</b> <input checked="" type="checkbox"/> ACH debit (Required for 2-9)	<b>Billing notification delivery method:</b> <input checked="" type="checkbox"/> Email	
<b>Do you want consolidated billing for dental and vision, if applicable?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Apply consolidated billing to all billing divisions?</b> <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		
<b>How will we receive COBRA enrollment?</b> <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
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**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
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**SECTION G: Dental Employer Contributions and Participation**

Total number of eligible employees: _____ Total number enrolling: _____	<b>Effective Date:</b> ____/____/____ (MM/DD/YYYY)
Contributions: For Employee: _____% For Dependents: _____%	<b>Contract Term:</b> ____/____/____ to ____/____/____ (MM/DD/YYYY)

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

<p><b>CO-INSURANCE</b> (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><b>ADDITIONAL PLAN FEATURES</b> (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)
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Basic Services	%																							
Major Services	%																							
Orthodontics	%																							
<input type="checkbox"/> CheckUp Plus™ <input type="checkbox"/> Composite Fillings <input type="checkbox"/> Orthodontics (Child only)																								

<b>Calendar Year Deductible:</b>	<b>Benefit Waiting Periods:</b>	<b>Benefit Maximums:</b>
\$ ____ \$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 (DDAZ)** (Selections must match vision quote. Please attach original quote for processing.)

<p><b>Select your plan:</b></p> <p><input type="checkbox"/> Diamond</p> <p><input type="checkbox"/> Platinum</p> <p><input type="checkbox"/> Gold</p> <p><input type="checkbox"/> Silver</p> <p><input type="checkbox"/> Bronze</p>	<p><b>ADDITIONAL PLAN FEATURES</b></p> <p><input type="checkbox"/> One &amp; Sun™</p>								
<p><b>Quoted Rates:</b>    <input type="checkbox"/> Two-tier    <input type="checkbox"/> Three-tier    <input type="checkbox"/> Four-tier</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%; padding: 5px;">Employee only</td> <td style="width:30%; padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">Employee + spouse (employee + one dependent)</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">Employee + children (employee + two dependents)</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">Employee + family</td> <td style="padding: 5px;">\$ _____</td> </tr> </table>		Employee only	\$ _____	Employee + spouse (employee + one dependent)	\$ _____	Employee + children (employee + two dependents)	\$ _____	Employee + family	\$ _____
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	
<b>Does your agency operate under your Social Security Number or Tax ID Number?</b>			
<input type="checkbox"/> Social Security Number: _____ <input type="checkbox"/> Tax ID Number: _____			
_____			
Agent Signature		National Producer Number (Agent)	National Producer Number (Agency)
General Agent Name		General Agency Name	
<b>Does your general agency operate under your Social Security Number or Tax ID Number?</b>			
<input type="checkbox"/> Social Security Number: _____ <input type="checkbox"/> 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)	



# 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
_____ /_____/_____	_____ /_____/_____
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](mailto: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)
Dental Plan: Premier, PPO plus Premier, PPO, enhanced Premier, Vision
Option: High/Buy-up, Low/Base
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, Marital Status (Single, Married), Employee's Last Name, First, MI, Gender (M, F, U), Home Address (Mailing), Date of Birth (MM/DD/YYYY), City, State, Zip, Email

SECTION C: Dependent Information

Table with 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? YES - Please check the appropriate box(es) and complete Section D NO - Please skip to Section E
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), 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)

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](http://www.deltadentalaz.com) under privacy policy or contact Customer Service, Phone: 602.938.3131 or 800.352.6132, Email: [customerservice@deltadentalaz.com](mailto:customerservice@deltadentalaz.com).

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## 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.*