

Employer Group Master App: Flex Choice Plan

Thank you for choosing Delta Dental. This Employer Group Master App may be used to apply for the Flex Choice Plan which offers your employees a choice of several dental and vision programs offered by Delta Dental. The PPO dental plans are underwritten and administered by Delta Dental of Arizona (DDAZ). The vision plans are underwritten by DDAZ and administered by EyeMed. This combined application is being used for your convenience only. Each dental and vision 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 _____	Student status up to age: _____ 26 _____	
Domestic partner coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Waive eligibility period on initial enrollees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
New hire waiting period: <input type="checkbox"/> 1st of the month following _____	Qualifying events are effective: <input type="checkbox"/> 1st of the month following event (DDAZ standard)	Member Termination: <input type="checkbox"/> End of month (DDAZ standard)
How will we receive <u>initial</u> enrollment? <input type="checkbox"/> Enrollment Spreadsheet (Must follow DDAZ standard format) <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 average dependent report? 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 type="checkbox"/> ACH credit <input type="checkbox"/> ACH debit (Required for 2-9) <input type="checkbox"/> Check	Billing notification delivery method: <input checked="" type="checkbox"/> Email

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"/> Electronic File Feed <input type="checkbox"/> Enrollment Forms <input type="checkbox"/> Excel Spreadsheet (Follow PPO standard file layout.)		

FORM CONTINUES TO NEXT PAGE.

SECTION E: Current Dental & Vision 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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Does your company currently have a vision plan? Yes No

Name of Carrier(s)	Reason for Change
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SECTION F: Dental & Vision Employer Contributions and Participation

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: _____	Contributions: For Employee: _____% For Dependents: _____%
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Vision Employer Contributions and Participation

Total number of eligible employees: _____ Total number enrolling: _____	Contributions: For Employee: _____% For Dependents: _____%
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Dental & Vision Effective Dates & Contract Terms

Effective Date: ____/____/____ **Contract Term:** ____/____/____ to ____/____/____
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

SECTION H: Plan Offering Information

FLEX CHOICE PLAN

Dental Plans	Plan 1 \$500 MAX (10001)	Plan 2 \$1,000 MAX (20001)	Plan 3 \$1,500 MAX (30001)	Plan 4 \$2,500 MAX (40001)
Network	MAC PPO	MAC PPO	MAC PPO	PPO + Premier
Deductible	\$50/\$150	\$50/\$150	\$50/\$150	\$50/\$150
Annual Maximum	\$500	\$1,000	\$1,500	\$2,500
Orthodontia Lifetime Max (Child Only)	N/A	N/A	\$1,000	\$1,500
Orthodontia Coverage (Child Only)	N/A	N/A	50%	50%
Preventive & Diagnostic	100%	100%	100%	100%
Basic	50%	70%	80%	80%
Major	25%	40%	50%	50%
Rates				
EE Only	\$19.73	\$33.18	\$48.10	\$62.12
EE + Spouse	\$40.29	\$67.75	\$98.24	\$126.85
EE + Child(ren)	\$46.44	\$78.11	\$125.59	\$167.71
EE + Family	\$73.47	\$123.57	\$195.02	\$258.95

Vision Plans	Plan 1: 813	Plan 2: 804	Plan 3: 805
<input checked="" type="checkbox"/> With One & Sun™			
Rates			
EE Only	\$8.66	\$9.52	\$11.24
EE + Spouse	\$17.32	\$19.03	\$22.49
EE + Child(ren)	\$14.43	\$16.09	\$19.45
EE + Family	\$23.70	\$26.30	\$31.56

Quoted Rates: Four-tier
Funding Type: Pooled

FORM CONTINUES TO NEXT PAGE.

SECTION I: 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

SECTION J: 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?			
<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	
Does your general agency operate under your Social Security Number or Tax ID Number?			
<input type="checkbox"/> Social Security Number: _____		<input type="checkbox"/> Tax ID Number: _____	
_____ General Agent Signature		_____ National Producer Number (Agent)	_____ National Producer Number (Agency)

FORM CONTINUES TO NEXT PAGE.

SECTION K: 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 L: 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.
Scottsdale, Suite 400, AZ 85254
Email: billing@deltadentalaz.com
Fax: 602.548.5071