

# 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: <u>26</u>		Student status up to age: <u>26</u>
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
<b>New hire waiting period:</b> <input type="checkbox"/> 1st of the month following _____	<b>Qualifying events are effective:</b> <input type="checkbox"/> 1st of the month following event (DDAZ standard)	<b>Member Termination:</b> <input type="checkbox"/> End of month (DDAZ standard)
<b>How will we receive <u>initial</u> enrollment?</b> <input type="checkbox"/> Enrollment Spreadsheet (Must follow DDAZ standard format) <input type="checkbox"/> Electronic File Feed	<b>How will we receive <u>ongoing</u> enrollment?</b> <input type="checkbox"/> Benefit Manager Toolkit (portal) <input type="checkbox"/> Electronic File Feed	<b>Would the group like to receive an overage 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
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		
<b>How will we receive COBRA enrollment?</b> <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

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

Name of Carrier(s)

Reason for Change

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: \_\_\_\_\_%

Vision Employer Contributions and Participation

Total number of eligible employees: \_\_\_\_\_  
Total number enrolling: \_\_\_\_\_

Contributions: For Employee: \_\_\_\_\_%  
For Dependents: \_\_\_\_\_%

Dental & Vision Effective Dates & Contract Terms

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_(MM/DD/YYYY) Contract Term: \_\_\_\_/\_\_\_\_/\_\_\_\_\_(MM/DD/YYYY) to \_\_\_\_/\_\_\_\_/\_\_\_\_\_(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  
☒ With One & Sun™

	Plan 1: 813	Plan 2: 804	Plan 3: 805
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	
<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)

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)	



## 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
<div> <div></div> <div> <div></div> <div></div> </div> </div> <div>Authorized Signature</div> <div> <div></div> <div></div> </div> <div>Date</div>	<div> <div></div> <div> <div></div> <div></div> </div> </div> <div>Authorized Signature</div> <div> <div></div> <div></div> </div> <div>Date</div>

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