DELTA DENTAL

2010 Group Dental Application

Self Insured (ASC) Plans

☐ PPO ☐ Passive PPO
☐ Voluntary ☐ Premier

Section 1 — GROUP INFORMATION: (Please Type or Print Legibly)

Group Name: (Please do not abbreviate)			Phone:	Fax:
Address:			**E-mail Address:**	
City:	**State:**	**Zip Code:**	**Type of Business:**	
Primary Contact:			**SIC Code:**	
Would you like to receive monthly billings via Web Retrieval? ☐ Yes ☐ No				
Would you like information about On-line eligibility? ☐ Yes ☐ No				
Billing Address (*if different than above*):			**Billing Contact:**	

Section 2 — PLAN DESCRIPTION

Effective Date: _____/1/2010

PLEASE ATTACH COPY OF PROPOSAL SHEET WITH THE DESIRED COVERAGE

D&P: ____ % Deductible: $ _____ (per person)
Basic: ____ % $ _____ (per family)
Major: ____ % Annual Max: $ _____
Orthodontics: %

Deductibles and maximums:
☐ Contract year
☐ Calendar year

Number of Eligible Employees:

Orthodontics Information:

Prior Ortho? ☐ Yes ☐ No
If yes, name of carrier: _____
When did/will coverage end? _____
Ortho Covered on Takover? ☐ Yes ☐ No
12-month wait? ☐ Yes ☐ No
Adult Ortho: ☐ Yes ☐ No
Ortho Age Limit: _____
Lifetime Ortho Max: _____
Sep. from Annual Max: ☐ Yes ☐ No

Dependent Ages:

Dependents to age: _____
Students to age: _____

New Hire Waiting Period:

First of the month following: _____ days
Immediately following: _____ days

Cobra Billing Information:

It is the group's responsibility to provide COBRA information to eligible employees. Upon request, Delta Dental of Kansas will provide direct billing and premium collection for COBRA participants. If you wish to have Delta Dental handle the COBRA billing for eligible participants, please complete and attach the COBRA BILLING DESIGNATION FORM.

☐ No, have Delta Dental bill the employer for COBRA participants.

☐ Yes, have Delta Dental bill COBRA participants directly at rates shown at the right which are 2% above funding levels.

Employee $ _____
E + _____ $ _____
E + _____ $ _____
Family $ _____

Financial Arrangements:

ASC RATE

Amount per enrolled employee per month

$_____

CLAIMS BILLING

☐ Weekly
☐ Monthly
$_____ Pre-Fund Amount

Additional Information

Section 125:	☐ YES	☐ NO
Request Major Surgery:	☐ YES	☐ NO
Enrollment Data:	☐ FORMS	☐ ELECTRONIC
	☐ ONLINE	☐ OTHER
ID Cards: ☐ NONE ☐ CARD & CERT.	☐ CARD	☐ CERTIFICATE
Posterior Composites:	☐ YES	☐ NO
Student Verification:	☐ YES	☐ NO
Domestic Partners:	☐ YES	☐ NO
Other (please attach):	☐ YES	☐ NO

Agent of Record (*If applicable)*

Agent: _____
Agency: _____
Agent's phone number: _____
City/State: _____ Zip Code: _____
Agent's email address: _____
Agent's Signature: _____

Section 3 — SIGNATURE / AUTHORIZATION

The applicant acknowledges that they have selected this plan based upon written information provided by Delta Dental of Kansas and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan document, specifically known as the Agreement to Provide Dental Benefits. This plan document will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan. I hereby apply for coverage indicated above. I certify that all information provided in this application is accurate and complete to the best of my knowledge and belief. By my signature below I agree to be bound by the terms and conditions of the plan document. I understand that Delta Dental of Kansas may choose not to accept this application at its sole discretion. I designate the above named broker as my agent of record to act on my behalf.

Company Representative's Signature: _____ Date: _____

Printed Name of Company Representative: _____ Title: _____