2010 Group Dental Application

VOLUNTARY Community Rated-Programs

10-200 Enrolled Employees

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

There is no need to attach a binder check. Delta Dental of Kansas will bill the group.

Would you like DDKS to bill individuals for COBRA? ☐ Yes (attach signed billing designation) ☐ No

Billing Address (*if different than above*):

Billing Contact:

Section 2 — **PLAN DESCRIPTION**

Effective Date: _______/1/2010

Number of Enrolled Employees:

Eligible Employees:

Circle choice of each of the following and show rates below.

Rate Tier:	**2**	**3**	**4**
Base Plan:	**1**	**2**	**3**
Network:	**Premier**	**PPO**	**EPO**

Submission Checklist

Please include the following with this application:

________ Employer Wage & Tax Statement

________ All enrollment forms - including waivers

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

Base Monthly Premium / **Additional Monthly Premium for Optional Benefits**

Base Monthly Premium		Posterior Composites	$50x3 Deductible
Employee:	$ ________	+ $________	+ $________
E + _______	$ ________	+ $________	+ $________
E + _______	$ ________	+ $________	+ $________
Family	$ ________	+ $________	+ $________

$25x3 Deductible	$1,500 Maximum	Orthodontics	Endo & Perio in Major
+ $________	+ $________	+ $________	- $________
+ $________	+ $________	+ $________	- $________
+ $________	+ $________	+ $________	- $________
+ $________	+ $________	+ $________	- $________

TOTAL Premium:

Employee	$ ________
Emp+ ____	$ ________
Emp+ ____	$ ________
Family	$ ________

Contract Provisions

Waiting Period for New Hires:

First day of the month following 90 days

Deductible:

○ $25 x 3

○ $50 x 3

○ $75 x 3

Annual Maximum: $1,000

Deductibles and maximums are calendar year.

Participation must be the greater of:

25% of eligible employees or

10% enrolled employees

Agent of Record (*If applicable*):

Agent: ____________

Agency: ____________

Agent's phone number: ____________

City/State: ____________ Zip: ____________

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: ____________