DELTA DENTAL

Delta Dental of Minnesota

Employer Application
Delta Dental Small Business Clients

PART A – Client Information

Plan Effective Date: ____

Legal Company Name: ____

Physical Address: ____ Phone: (   ) ____________________

City: ______________________________ State: ____________ Zip Code: ____________________

Mailing Address ☐ Same as client physical location: ____

City: ______________________________ State: ________ Zip Code: ____________________

Does your company currently have a dental plan? ☐No ☐Yes (name of carrier) ______________________________

(Include a copy of most recent billing statement and benefit summary) Prior Plan Start Date: ______________________________

Total Number of Eligible Employees: _________

Estimated enrolled Subscriber count: ___________

Client Contact Information

First Name: ____________________ Last Name: ______________________________

Title: ____

Contact Type: ☐ [General] ☐ [Renewal] ☐ [Billing] ☐ [Mailing] ☐ [Materials] ☐ [Overage Dependent]

Telephone: ______________________ Ext: _________ Cell: ____________________

Email Address: ____

☐ Same as Client Physical Location

Mailing Address ____

City: ______________________________ State: __________ Zip Code: ____________________

Additional Client Contact Information (if applicable)

First Name: ____________________ Last Name: ______________________________

Title: ____

Contact Type: ☐ [General] ☐ [Renewal] ☐ [Billing] ☐ [Mailing] ☐ [Materials] ☐ [Overage Dependent]

Telephone: ______________________ Ext: _________ Cell: ____________________

Email Address: ____

☐ Same as Client Physical Location

Mailing Address ____

City: ______________________________ State: __________ Zip Code: ____________________

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Client – Employer Services Portal Registration

With the Employer Services Portal, you can enroll a new member, update existing members, view eligibility and dental benefits. In addition, your monthly invoice and other billing details are provided to you exclusively through the Employer Services Portal.

Select a Client Super User within your company and complete the information below. This Client Super User will create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will e-mail the Client Super User with registration information and additional instructions. **The Client Super User must be an employee of the company.**

Client Super User Name: ______________________ Title: ______________________

Email: ______________________ Phone Number: ______________________

PART B – Dental Program Options (choose only one)

Available for groups with 2 - 100 eligible employees, minimum of 2 employees must enroll.
*Waiting periods are applicable, unless otherwise indicated. Waiting periods may also be waived with twelve (12) months of prior comparable coverage for all **initial enrollment** on plan effective date. This application does not guarantee coverage.*

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Solutions Dual Option (with or without child orthodontic coverage):**

Plan waiting periods do not apply

☐ Yes, we accept child orthodontic coverage
☐ No, we decline child orthodontic coverage

Please confirm sold plan rates

Employee	______
Employee + Spouse	______
Employee + Child(ren)	______
Family	______

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Solutions 1000, 1500, and 2000:**

Annual Plan Maximum Options *Please check (✓) one below:*

☐ $1,000 per person per year
☐ $1,500 per person per year
☐ $2,000 per person per year (with child orthodontic coverage)

Please confirm sold plan rates

Employee	______
Employee + Spouse	______
Employee + Child(ren)	______
Family	______

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Flex (with or without child orthodontic coverage):**

Annual Plan Maximum Options *Please check (✓) one below:*

☐ $1,000 per person per year
☐ $1,500 per person per year

☐ Yes, we accept child orthodontic coverage
☐ No, we decline child orthodontic coverage

Please confirm sold plan rates

Employee	______
Employee + Spouse	______
Employee + Child(ren)	______
Family	______

☐ **Delta Dental PPO Plus Premier™ - Pathfinder 1 - 6:**

Please check (✓) one below:

☐ Pathfinder 1
☐ Pathfinder 2
☐ Pathfinder 3 - Plan waiting periods do not apply
☐ Pathfinder 4 - With child orthodontic coverage
☐ Pathfinder 5
☐ Pathfinder 6 - Plan waiting periods do not apply

Please confirm sold plan rates

Employee	______
Employee + Spouse	______
Employee + Child(ren)	______
Family	______

Continued

PART C – Broker of Record - Completion of all fields is required

Broker Name: ______________________________ **Agency:** ______________________________

Address: ____

City: ______________________________ **State:** __________ **Zip Code:** ________________

Phone: ______________________________ **E-mail Address:** ______________________________

______________________________ ______________________________

Broker Signature / Insurance Broker License ID Number **Tax ID Number**

Note: Commissions will be paid to this TIN

BROKER SERVICES PORTAL

With the Broker Services Portal, the Broker of Record can update and view the client's eligibility and access the client's billing details. The Broker/Agency will work with their Agency's Broker Super User, who will add the appropriate user permissions to the Broker's access.

PART D – Premium Remittance and Submission

The first month's premium payment must be received in order for Delta Dental to pay claims for your members.

Please submit your first month's premium with your application:

1. Select Payment Option: ☐ **ACH** ☐ **Check** **Make payable to: Delta Dental of Minnesota and mail payments to**: Delta Dental of Minnesota, NW 5772, PO Box 1450, Minneapolis, MN 55485-5772
2. Complete the Employer Dental Contract Application. Retain a copy for your files.
3. Have each employee complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator.
4. Send the Employer Dental Contract Application, completed Enrollment Forms or approved Enrollment spreadsheet, and corresponding Dental Proposal to: DeltaDentalConnect@DeltaDentalMN.org

For questions call 1-800-906-5250 or DeltaDentalConnect@DeltaDentalMN.org

For information on Delta Dental of Minnesota's Privacy Practices, please see the Notice of Information Practices found at: https://www.DeltaDentalMN.org/about-us/hipaa-privacy-notice.

Client Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the Company (Company as named in Part A above) and agree to provide substantiating evidence when requested.

If Delta Dental accepts this application, Delta Dental will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Coverage under this plan may be subject to rescission when an individual seeking coverage performs an act, or omission that constitutes fraud as well in the event an individual makes an intentional misrepresentation or omission of material fact, as prohibited by the terms of the health plan. If issued, the contract may become null and void at the option of Delta Dental if upon renewal, the number of enrolled employees becomes less than two.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

______________________________ ______________________________ ______________________________

Signature of Authorized Company Official Title Date

______________________________ ______________________________

Client Administrator/Future Correspondence Contact (please print) Title

______________________________ ______________________________

Phone Number Email Address