DELTA DENTAL

Delta Dental of Minnesota

Master Contract Application for Certified Health Care Reform Group Dental Plans

PART A – COMPANY INFORMATION

Legal Company Name_____

Address _____ Phone (____) _____

City _____ State_____ Postal Code _____

Plan Effective Date _____

Total Number of Eligible Employees_____

Eligibility probationary period for new employees: First of the month following: _____ Other:_____

Type of Coverage: ☐ Employee Only ☐ Employee and Dependents ☐ Child Only (to age 19)

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

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

CLIENT CONTACT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name_____ Last Name _____

Title _____

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

Telephone:_____ Ext: _____ Cell:_____

Fax:_____ Email Address:_____

☐ Same as Client Physical Location Mailing Address: _____

City_____ State_____ Postal Code_____

OTHER CLIENT CONTACT INFORMATION (if the contact is different from above)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name_____ Last Name _____

Title_____

Contact Type: ☐ General ☐ Renewal ☐ Mailing ☐ Materials ☐ Overage Dependent

Telephone:_____ Ext: _____ Cell: _____

Fax: _____ Email Address:_____

☐ Same as Client Physical Location

Address:_____

City _____ State_____ Postal Code _____

CLIENT – EMPLOYER SERVICES PORTAL REGISTRATION

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

Select a Client Administrator within your company and complete the information below. This Client Administrator will be able to create and maintain user accounts, enabling immediate access for your Employer Services Portal users. Delta Dental will send the Client Administrator an e-mail with registration information and additional instructions.

Client Administrator Name: _____ Title: _____

Email: _____ Phone Number: _____

Note: The Client Administrator must be an employee of the client

PART B – DENTAL PLANS

Pediatric Dental Plan – for members under age 19 Per Member Per Month Rate Sold

☐ Delta Dental Kids Plan _____

Adult Dental Plan – for members age 19 and older CHECK ONE IF APPLICABLE:

☐ Delta Dental Bronze + Kids Plan _____

☐ Delta Dental Silver + Kids Plan _____

☐ Delta Dental Gold + Kids Plan _____

☐ Delta Dental Platinum + Kids Plan _____

PART C – BROKER OF RECORD – *Completion of all fields required*

Name _____ Agency _____

Address _____

City _____ State _____ Postal Code _____

Phone _____ E-mail Address: _____

_____

Broker Signature / Insurance Broker License ID Number

Tax ID

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 receive access to the client's billing details. The Broker/Agency will work with their Agency's Broker Administrator, 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 – Include ACH Authorization form and voided check

   ☐ CHECK ☐ WIRE ☐ OTHER _____

2. Complete Master Dental Contract Application. Retain a copy for your files.
3. Have each employee complete and sign a Membership Enrollment form or be identified on an approved Enrollment spreadsheet completed by the Group Administrator.
4. Send the Master Dental Contract Application, completed Membership Enrollment forms or approved Enrollment spreadsheet, Dental Proposal and the first month of premium to:

   Delta Dental of Minnesota, **ATTN: Delta Dental Connect℠**

   500 Washington Ave South, Suite 2060

   Minneapolis, MN 55415-1163

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

Group Administrator:
By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by 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. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than five.

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 BOX

Signature of Authorized Company Official	Title	Date
Client Administrator/Future Correspondence Contact (please print)	Title	
_____	_____	
( )	( )	
Phone Number	Fax Number	Email Address