Delta Dental of Minnesota

Medica Master Application
Delta Dental Small Business Clients
Minnesota

PART A - Client Information

Legal Company Name ______

Physical Address ______ Phone ( ) ______

City ______ State ______ Zip Code ______

Mailing Address ☐ *Same as Client Physical Location* ______

City ______ State ______ Zip Code ______

Plan Effective Date: ______

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

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 ______

Client Contact Information

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First Name ______ Last Name ______

Contact Type ☐ General ☐ Billing ☐ Renewal ☐ Mailing ☐ Materials

Phone ( ) ______ EXT ______ Mobile ( ) ______

Email ______ Fax ______

Mailing Address ☐ *Same as Client Physical Location* ______

City ______ State ______ Zip Code ______

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First Name ______ Last Name ______

Contact Type ☐ General ☐ Billing ☐ Renewal ☐ Mailing ☐ Materials

Phone ( ) ______ EXT ______ Mobile ( ) ______

Email ______ Fax ______

Mailing Address ☐ *Same as Client Physical Location* ______

City ______ State ______ Zip Code ______

Delta Dental of Minnesota

Medica Master Application
Delta Dental Small Business Clients
Minnesota

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

Client Administrator Name ______________________ Title ______________________

Email ______________________ Phone (   ) ______________________

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

PART B – Delta Dental PPO Plus Premier™ - Medica Dental Program Options (choose only one)

☐ Delta Dental PPO Plus Premier™ -Medica Plan available for groups with 2 -100 eligible employees, minimum of 2 employees must enroll. Medica Dental Plan must be written in conjunction with a Medica Health Plan.

Plan Options Please check (✓) one below:

☐ **Medica Plan 1 -** $750 per person per year plan maximum, $50/$150 deductible per person/per family (calendar year), no orthodontic coverage

☐ **Medica Plan 2 -** $1,000 per person per year plan maximum, $50/$150 deductible per person/per family (calendar year), optional orthodontic coverage*

☐ **Medica Plan 3 -** $1,500 per person per year plan maximum, $25/$75 deductible per person/per family (calendar year), optional orthodontic coverage*

***Optional Orthodontic Coverage -** Available with Medica Plan option 2 or 3 only, minimum of 2 employees must be enrolled. Coverage for dependent children from ages 8 up to age 19, coverage at 50%, Lifetime Orthodontic Plan Maximum $1,000

☐ Yes, we accept orthodontic coverage

☐ No, we decline orthodontic coverage

Please confirm sold plan rates:

Employee ____________

Employee + Spouse ____________

Employee + Child(ren) ____________

Family ____________

Delta Dental of Minnesota

Medica Master Application
Delta Dental Small Business Clients
Minnesota

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

Broker or Medica Representative Name ______________________________

Agency or Medica Office ______________________________

Mailing Address ______________________________

City ______________________ State ____________ Zip Code ____________

Email ______________________ Phone ( ) ____________

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 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** ☐ **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 Plan Master Dental Contract Application.
3. Each eligible employee must complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator.
4. Send the Dental Contract Application, completed Enrollment Forms or approved Enrollment spreadsheet, corresponding Dental Proposal, and copy or details of first months premium payment(if applicable) to:

   Delta Dental of Minnesota
   ATTN: Delta Dental Connect℠
   500 Washington Ave South, Suite 2060
   Minneapolis, MN 55415-1163

   Completed applications and related materials may also be emailed to:
   Deltadentalconnect@deltadentalmn.org

For questions call 1-800-906-5250 or Deltadentalconnect@deltadentalmn.org

Delta Dental of Minnesota

Medica Master Application
Delta Dental Small Business Clients
Minnesota

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. 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 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 Box

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