

Application Instructions

- Step 1:** Complete **Sections 1 and 2** for all groups.
- Step 2:** Complete the appropriate section(s) for the product(s) being offered.
- Section 3: aXcess™** - Available to businesses with 2-99 eligible employees. Available as a single option plan only.
- Section 4: Delta Dental PPOSM plus Premier** - Available to businesses with 5-99 eligible employees. May be offered as a single option, high/low option or as the high plan of a dual offering with DeltaCare.
- Section 5: Delta Dental PPOSM Exclusive Provider Network (EPN)** - Available to businesses with 5-99 eligible employees in the following areas of Virginia only: Hampton Roads/Tidewater, Richmond and Northern Virginia Metropolitan. Available as a single option plan only.
- Section 6: Delta Dental Premier®** - Available to businesses with 5-99 eligible employees. May be offered as a single option, high/low option or as the high plan of a dual offering with DeltaCare.
- Section 7: Voluntary Plans: Delta Dental PPO plus Premier or Delta Dental Premier** - Available to businesses with 10-300 eligible employees. May be offered as a single option, high/low option or as the high plan of a dual offering with DeltaCare.
- Section 8: DeltaCare®** - May be offered as a single option plan or as the low plan of a dual offering with any Delta Dental PPO plus Premier or Delta Dental Premier high plan.
- Step 3:** Complete **Sections 9 and 10** for all groups. Group administrator must sign and date.
- Step 4:** Complete **Section 11** (if applicable) with agent information. Agent must sign and date.

REQUESTED EFFECTIVE DATE: ____ / ____ / ____ **CONTRACT PERIOD:** ____ / ____ / ____ to ____ / ____ / ____

SECTION 1: Group Information (Please print clearly, using black ink.)

Group Name		Group Number	
Physical Address	City	State	ZIP
Mailing Address (if different from physical address)	City	State	ZIP
Administrative Contact	Email Address	Telephone ()	Fax ()

NOTE: Delta Dental sends monthly invoices in an electronic format. If the group requires paper monthly invoices, please indicate billing address below.

Billing Contact (Primary)	Email Address		
Telephone ()	Fax ()		
Billing Contact (Secondary)	Email Address		
Telephone ()	Fax ()		
Billing Address	City	State	ZIP

Nature of Business	EIN/TIN#	North American Industry Classification System (NAICS Code)
Form 5500 required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan Year: _____ to _____	Send to: <input type="checkbox"/> Billing Contact <input type="checkbox"/> Administrative Contact <input type="checkbox"/> Agent

Print ID cards with: Social Security Number (SSN) Alternate Identification Number (other than SSN)
Print correspondence/reports with: Social Security Number (SSN) Alternate Identification Number (other than SSN)
 If Alternate Identification Number is checked above, the number will be assigned by: Group Delta Dental of Virginia

SECTION 2: Monthly Rates & Employer Contribution (Non/Contributory Plans Only)

Rates: Employee: \$ _____ Emp/Spouse \$ _____ Emp/Child(ren) \$ _____ Emp/Family \$ _____

Rates for DeltaCare option or low option of a high/low dual offering (if applicable):

Employee: \$ _____ Emp/Spouse \$ _____ Emp/Child(ren) \$ _____ Emp/Family \$ _____

Single Plan Offering : Contribution to Employee Rate _____% **Dual Plan Offering:** Contribution to Employee Rate _____%

SECTION 3: aXcess (2-99 eligible employees)

Benefit Options Non/Contributory	<input type="checkbox"/> 100/80/10/10 <input type="checkbox"/> 100/80/25/25
Deductible	\$50 Lifetime
Annual Maximum	\$2,000
Major (Type III)	Covered – No Benefit Waiting Period
Ortho (Type IV)	Covered – \$500 Lifetime Maximum, No Benefit Waiting Period

SECTION 4: Delta Dental PPO plus Premier (5 – 99 eligible employees)

Check one	<input type="checkbox"/> Single Option - Choose the appropriate Benefit Option below, then complete the Single Option column, or <input type="checkbox"/> High/Low Option* - Choose the appropriate Benefit Option below, then complete both High and Low columns, or <input type="checkbox"/> Dual Offering with DeltaCare - Choose the appropriate Benefit Option below, then complete only the High column and Section 8.					
Benefit Options Non/Contributory	<input type="checkbox"/> 100/80/50/50 Passive		<input type="checkbox"/> 100/100 90/80 60/50 50/50 Option 1 Active		<input type="checkbox"/> 100/90 80/70 50/50 50/50 Option 2 Active	
	Low Option*	High Option or Single Option	Low Option*	High Option or Single Option	Low Option*	High Option or Single Option
Deductible (Annual)	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50
Annual Maximum & Lifetime Orthodontic Maximum (if applicable)	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500
Diagnostic/ Preventive & Basic Care (Type I & II)	Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III		Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III		Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III	
Majors (Type III) (Type I & II required) <i>Indicate if covered and benefit waiting period.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months
Ortho (Type IV) ** (Type I-III required) <i>Indicate if covered and benefit waiting period.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months

* If coverage is only for Type I and II benefits, and "Move to Type III" is selected, then Endodontics/Periodontics/Oral Surgery services are **not** covered benefits.
 ** In order for Type IV (orthodontic benefits) to be offered, a minimum of ten (10) employees must be enrolled.

SECTION 5: Delta Dental PPO Exclusive Provider Network [EPN] (5-99 eligible employees)

Enrollees must visit a Delta Dental PPO participating dentist to receive benefits. Services received by any dentist that does not participate in Delta Dental's PPO network will not be covered, with the exception of emergency services.
 Coverage for emergency services provided by a non-participating dentist is limited to a maximum of \$50 per contract year.

Benefit Option Non/Contributory	<input type="checkbox"/> 100/80/50/50
Deductible (Annual)	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50
Annual Maximum & Lifetime Orthodontic Maximum (if applicable)	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500
Diagnostic/ Preventive & Basic Care (Type I & II)	Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics/Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III
Majors (Type III) (Type I and II required) <i>Indicate if covered and benefit waiting period.</i>	Covered <input type="checkbox"/> Yes <input type="checkbox"/> No Waiting Period: <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months
Ortho (Type IV) ** (Type I-III required) <i>Indicate if covered and benefit waiting period.</i>	Covered <input type="checkbox"/> Yes <input type="checkbox"/> No Waiting Period: <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months

* If coverage is only for Type I and II benefits, and "Move to Type III" is selected, then Endodontics/Periodontics/Oral Surgery services are **not** covered benefits.
 ** In order for Type IV (orthodontic benefits) to be offered, a minimum of ten (10) employees must be enrolled.

SECTION 6: Delta Dental Premier (5-99 eligible employees)

Check one	<input type="checkbox"/> Single Option - Complete Single Option column, or <input type="checkbox"/> High/Low Option* - Complete both High and Low columns, or <input type="checkbox"/> Dual Offering with DeltaCare - Choose the appropriate Benefit Option below, then complete only the High column and Section 8.					
Benefit Option Non/Contributory	<input type="checkbox"/> 100/80/50/50					
	Low Option*			High Option or Single Option		
Deductible	<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50			<input type="checkbox"/> \$0 <input type="checkbox"/> \$25 <input type="checkbox"/> \$50		
Annual Maximum & Lifetime Ortho Maximum (if applicable)	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500			<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500		
Diagnostic/ Preventive & Basic Care (Type I & II)	Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics/Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III					
Majors (Type III) (Type I & II required) <i>Indicate if covered and benefit waiting period.</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		
Ortho (Type IV) ** (Type I-III required) <i>Indicate if covered and benefit waiting period.</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> None <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		
<p>* If coverage is only for Type I and II benefits, and "Move to Type III" is selected, then Endodontics/Periodontics/Oral Surgery services are not covered benefits.</p> <p>** In order for Type IV (orthodontic benefits) to be offered, a minimum of ten (10) employees must be enrolled.</p>						

SECTION 7: VOLUNTARY PLANS (10-300 eligible employees)

Check one	<input type="checkbox"/> Single Option - Choose the appropriate Benefit Option below, then complete the Single Option column, or <input type="checkbox"/> High/Low Option* - Choose the appropriate Benefit Option below, then complete both High and Low columns, or <input type="checkbox"/> Dual Offering with DeltaCare - Choose the appropriate Benefit Option below, then complete only the High column and Section 8.					
Benefit Options Voluntary	<input type="checkbox"/> 100/80/50/50 Delta Dental PPO plus Premier Passive		<input type="checkbox"/> 100/100 90/80 60/50 50/50 Delta Dental PPO plus Premier Active		<input type="checkbox"/> 100/80/50/50 Delta Dental Premier	
	Low Option*	High Option or Single Option	Low Option*	High Option or Single Option	Low Option*	High Option or Single Option
Deductible (Annual)	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50
Annual Maximum & Lifetime Orthodontic Maximum (if applicable)	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1250 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500
Diagnostic/ Preventive & Basic Care (Type I & II)	Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III		Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III		Composite fillings on all teeth <input type="checkbox"/> Yes <input type="checkbox"/> No Endodontics/Periodontics Oral Surgery* <input type="checkbox"/> Type II OR <input type="checkbox"/> Move to Type III	
Majors (Type III) (Type I & II required) <i>Indicate if covered and benefit waiting period.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> 6-months <input type="checkbox"/> 12-months	
Ortho (Type IV) ** (Type I-III required) <i>Indicate if covered and benefit waiting period.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> 12-months		<input type="checkbox"/> Yes <input type="checkbox"/> No <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> 12-months	
<p>* If coverage is only for Type I and II benefits, and "Move to Type III" is selected, then Endodontics/Periodontics/Oral Surgery services are not covered benefits.</p> <p>** In order for Type IV (orthodontic benefits) to be offered, a minimum of ten (10) employees must be enrolled.</p>						

SECTION 8: DeltaCare

Benefit Options	<input type="checkbox"/> Plan 3A <input type="checkbox"/> Plan 4A
Limited Service Area	Hampton Roads/Tidewater, Richmond and Northern Virginia Metropolitan areas only

SECTION 9: Eligibility Information

All eligible employees (and dependants) who are employed by the Group on the inception date of the plan are immediately eligible for coverage. Each present or new employee is an "eligible employee" if he or she (1) works a minimum of 25 hours per week; (2) is certified as being eligible by the Group; (3) receives compensation from the Group; and (4) is a member of the group as specified in the Group Dental Contract.

Total Employees	Employees Ineligible for Benefits (-)	Covered by Other Insurance (-)	Total Eligible Employees (=)	Total Eligible Employees Enrolled
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New Hire Waiting Period: The length of time future employees must be employed before becoming eligible for insurance
 1st of the month following 90 days Match medical plan – Exact Date of Hire 1st of the month following (specify # of days) _____
 Other (specify # of days) _____

Domestic Partner Coverage: Yes No If yes, is coverage extended to children of domestic partner: Yes No
(NOTE: If offering domestic partner coverage, an affidavit or corporate policy outlining eligibility requirement(s) must be included with this application.)

Comments: _____

SECTION 10: Group Administrator Signature

The undersigned Group Administrator represents and warrants that he or she is authorized to act on the Group's behalf. All of the information contained in this application is true and correct to the best of his or her knowledge and belief. By signing below, the Group, acting through its authorized Group Administrator, acknowledges and agrees that it will be bound by the terms and conditions of Delta Dental's group contract.

Group Administrator Signature	Date
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SECTION 11: Agent Information (if applicable)

Agent's Name (PLEASE PRINT)	
Agent's License Number or SSN	Currently appointed with Delta Dental? <input type="checkbox"/> Yes <input type="checkbox"/> No
Commission Payable to (check one) <input type="checkbox"/> Agent <input type="checkbox"/> Agency	If payable to Agency, list name of Agency
Agency TIN#	Agency currently appointed with Delta Dental? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agent Signature	Date

TO AVOID PROCESSING DELAYS, PLEASE MAKE SURE YOU:

- Complete sections 1, 2, 9, 10 and 11 (if applicable) and choose the benefit option(s) for your group.
- Include most recent quarterly tax and wage statement.
- Include employee enrollment forms.
- Include a check for the first month's premium.
- If waiver of benefit waiting periods is requested, include prior carrier premium statements and benefit summary to document 12 months of prior coverage.
- If offering domestic partner coverage, include a copy of the employer's domestic partner affidavit or corporate policy.



The Benefits of Experience

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