DELTA DENTAL®

NEW BUSINESS GROUP APPLICATION

ATTN: SALES DEPARTMENT
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129
TEL: 1-800-451-1249
FAX: (617) 886-1129
www.deltadentalma.com

To ensure fast processing of your application, please complete the information below in its entirety.
The purpose of this form is to confirm the level of dental benefits, rates and billing information for your organization.
Acceptance of your application is subject to Delta Dental's Underwriting guidelines and approval.

EMPLOYER INFORMATION

Group Name: _____ Tax ID # _____

Physical Address: _____ City _____ State _____ Zip _____

Billing Address: _____ City _____ State _____ Zip _____

Phone: (_____)_____

HR Director: _____ E-mail address: _____

Day-to-Day Contact: _____ E-mail address: _____

Billing Contact: _____ E-mail address: _____

Previous Carrier: _____

COVERAGE

COVERAGE PERIOD

From ____ /____ /____

To ____ /____ /____

Terms of Agreement:

☐ One Year ☐ Two Years ☐ Other

☐ Delta Dental Premier National Coverage
☐ Delta Dental PPO *Plus Premier*
☐ Delta Dental PPO National Coverage
☐ DeltaCare ☐ (1) ☐ (2) ☐ (3) ☐ (4)
☐ DeltaCare USA ☐ (1) ☐ (2) ☐ (3)
☐ Delta Dental PPO *Plus Premier* Voluntary
☐ Delta Dental PPO *Plus Premier* Enhanced Voluntary
☐ Delta Dental Premier Table Voluntary
☐ Delta Dental Premier Enhanced Table Voluntary
☐ Delta Dental PPO *Plus Premier* Voluntary Incented Plan
☐ Delta Dental PPO Value Plan

PLAN DESIGN

	PLAN DESIGN IN	CO-INSURANCE OON
Type I	☐ _____ %	☐ _____ %
Type II	☐ _____ %	☐ _____ %
Type III	☐ _____ %	☐ _____ %

Annual Max. ☐ $ _____

DEDUCTIBLES

STANDARD	OTHER
☐ None	☐ $ _____
☐ $25/$75	☐ $ _____
☐ $50/$150	☐ $ _____

Applicable to type _____

RIDERS

STANDARD PLAN		OTHER
Children to Age:	☐ 26	☐ _____
Students to Age	☐ 26	☐ _____
Ortho to Age	☐ 19	☐ Any Age
	☐ Ortho LTM	☐ _____
Spousal Equivalents (Domestic Partners)	☐ Yes	☐ No

As defined by Federal HCRL guidelines

RATE & SUBSCRIBER COUNT

	Rate		Count		Total
Individual	$ _____	X	_____	=	_____
Employee + 1	$ _____	X	_____	=	_____
Family	$ _____	X	_____	=	_____
	$ _____	X	_____	=	_____
Total			_____	=	_____

COMPANY CONTRIBUTION

Your Company Contribution must be at least 50% of the total monthly premium that is listed in the total column in the Rate & Subscriber count box. This does not apply to Delta Dental Voluntary plans.

COMPANY CONTRIBUTION MUST = 50% or greater

BILLING OPTIONS

Your first month's premium should equal this total

☐ **FULLY INSURED**

First month's premium $ _____

Premium due w/application

☐ **SELF INSURED**

☐ Administrative Rate _____ %

☐ Per subscriber per month $ _____

Deposit due with application $ _____

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NEW BUSINESS GROUP APPLICATION CONTINUED

PARTICIPATION VERIFICATION

1. Total number of employees: _____
2. Number of employees eligible for dental benefits: _____
3. Number of employees you are enrolling with in the plan: _____
4. Number of employees waiving benefits due to alternative coverage through a spouse or another individual: _____
   (a letter or proof of waiver may be required)

ENROLLMENT

Initially	☐ Forms	☐ Electronic Tape	☐ Spreadsheet	Date enrollment will be sent by:
Ongoing	☐ Forms	☐ Electronic Tape	☐ Spreadsheet	_____ /_____ /_____

BROKER INFORMATION (IF APPLICABLE)

Contact Name: _____

Firm: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Pay to Firm or Pay to Broker: _____

Broker Signature: _____

I HEREBY APPLY FOR THE DELTA DENTAL OF MASSACHUSETTS PLAN AS OUTLINED ABOVE AND I DESIGNATE THE BROKER NAMED ON THIS FORM (IF APPLICABLE) HEREON TO ACT ON OUR ORGANIZATION'S BEHALF. NOTICE: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Company Representative Signature: _____

Print Name: _____

Title: _____ Date: _____

DELTA DENTAL INTERNAL USE ONLY

Underwriting Approval: _____ Group Number Assigned: _____ Additional Sub-locations: _____