DELTA DENTAL®

Clear Form

**DELTA DENTAL OF RHODE ISLAND**

# GROUP APPLICATION

The purpose of this form is to confirm the level of benefits, rates and billing information for the group specified below. Acceptance of the information outlined is subject to Delta Dental Underwriting approval.

## COMPANY INFORMATION

GROUP NAME:_____ PHONE: (_____)_____

BILLING ADDRESS:_____ FAX: (_____)_____

OTHER CO. ADDRESS_____ COMPANY WEB ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRESIDENT/CEO:_____ FINANCIAL CONTACT:_____ TITLE:_____

HR CONTACT:_____ TITLE:_____ ADMIN/BILLING CONTACT: _____

## PLAN DESCRIPTION – Benefit Highlights Attached: YES_____ NO _____

**FLEX PLAN**

TYPE I: _____% DEDUCTIBLE: $_____

TYPE II: _____% DEDUCTIBLE: $_____

TYPE III: _____% DEDUCTIBLE: $_____

PERIODONTICS: _____% DEDUCTIBLE: $_____

SEALANTS: _____%

ANNUAL MAX: _____

ORTHODONTICS:_____% ORTHO MAX: _____

DeltaUSA: yes_____ no_____

STUDENTS TO AGE: _____

OTHER RIDERS _____

**LEVEL PLAN**

LEVEL I: _____% DEDUCTIBLE: $_____

LEVEL II: _____% DEDUCTIBLE: $_____

CROWNS: _____% DEDUCTIBLE: $_____

LEVEL III: _____% DEDUCTIBLE: $_____

PERIODONTICS: _____% DEDUCTIBLE: $_____

SEALANTS: _____%

ANNUAL MAX: _____

ORTHODONTICS:_____% ORTHO MAX: _____

DeltaUSA: yes_____ no_____

STUDENTS TO AGE: _____

OTHER RIDERS _____

## FINANCIAL ARRANGEMENT Rate information attached Yes_____ No_____

**EFFECTIVE DATE** _____/01/_____ **THROUGH** _____/31/_____

**PREMIUM** _____ TERM OF AGREEMENT 1 YR._____ 2 YR._____% cap 3 YR. or OTHER_____% cap

**CONTINGENT** _____ TERM OF AGREEMENT 1 YR._____ 2 YR._____% cap 3 YR. or OTHER_____% cap

MIN _____% MAX _____% BILLING _____%

| | **# ENROLLED** | | **MONTHLY RATE** | | **TOTAL MO. PREMIUM** |
|---|---|---|---|---|---|
| SINGLE: | _____ | X | $ _____ | = | $ _____ |
| TWO PERSON: | _____ | X | $ _____ | = | $ _____ |
| FAMILY: | _____ | X | $ _____ | = | $ _____ |

FIRST MONTH ESTIMATED PREMIUM (***DUE WITH APPLICATION***): $ _____

**SELF INSURED** _____ DEPOSIT **(DUE WITH APPLICATION)**: $_____ ADMINISTRATIVE EXPENSE: _____

WORKING RATES: INDIVIDUAL: $_____ TWO PERSON: $_____ FAMILY: $_____

COMPANY CONTRIBUTION _____% $_____ #OF BENEFIT ELIGIBLE EMPLOYEES_____

## ENROLLMENT

ACCOUNT NAME ON ID CARD (if applicable)_____

FORMS: _____ ELECTRONIC: _____ ONLINE ENROLLMENT: _____ OTHER: _____ ID CARD: HOMES: _____ ACCOUNT: _____

## PLAN AUTHORIZATIONS

I HEREBY APPLY FOR THE DELTA DENTAL PLAN OUTLINED ABOVE. DATE:_____

COMPANY REPRESENTATIVE SIGNATURE: _____ TITLE: _____

BROKER NAME:_____ BROKER OF RECORD LETTER REQUIRED: ATTACHED: YES_____ NO _____

ACCOUNT/SALES EXECUTIVE:_____ DATE SUBMITTED: _____

GROUP NUMBER ASSIGNED:_____ - _____ CONTRACT REQUEST: YES_____ NO _____

UNDERWRITING _____ DATE _____ PRIOR DENTAL CARRIER _____

WHITE: UNDERWRITING YELLOW: COMPANY PINK: FILE COPY