Corporate Office
135 Wood Road
Braintree, MA 02184
781.848.4950

New Case Submission Checklist

Delta Dental of Massachusetts
Contributory Plans
With 2 or more employees

	To ensure that your applications are processed as quickly as possible, just follow this checklist	Check if Complete
1	**Employer** completes **HSA Membership Application.**	☐
2	**Employer** completes **Delta Dental Contributory Plans Employer Enrollment Form**.	☐
3	**Employer** provides copy of most recent **WR-1.**	☐
4	Each **employee** must complete individual **Enrollment Form.**	☐
5	Pay your **first premium, $5 monthly service fee and $25 annual membership fee**: • Pay over the phone: (781) 228-2222. Payment Confirmation #:_____ -or- • Complete Electronic Payment Request Form -or- • Enclose check payable to HSA *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*	☐
6	Enclose Annual Membership Fee of **$25 (Payable to HSA)** (see #5 instructions above) **-or-** If enrolling through an **Association or Chamber of Commerce, please indicate:** **Name of Association or Chamber:** _____ If not already a member of a participating Association or Chamber of Commerce, additional requirements may apply such as completing a membership application and paying dues.	☐
7	Send all required documents (including this checklist) to: **Corporate Office** 135 Wood Road Braintree, MA 02184 Sales Rep: Contact Info:	☐

PLEASE NOTE: Complete applications and premium payment for new business must be received by HSA at least 5 business days prior to the requested effective date.

All coverage will be effective on the 1st day of the month. Keep a copy of your application as your temporary ID. Once your enrollment have been approved and processed, you will receive a member confirmation by mail with your group number. Your permanent ID cards will be issued to you directly from the carrier. Permanent ID cards generally take 7-10 business days from date your enrollment was approved and processed.

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Membership Application

Please complete each section of this application. Failure to do so could delay enrollment.

Employer information

Employer name_____ Date business established (Mo./Yr.) _____/_____

Employer address _____

City _____State _____ Zip _____

Owner/principal contact name (first and last) _____ Title_____

Business Phone _____ Cell phone _____ Fax _____

Email _____ Website _____

Billing address _____

City_____State _____ Zip _____

Type of business ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ LLC ❑ Other: _____

Nature of business: _____

Employer tax ID# _____ SIC code_____

Do you regularly employ at least one individual that is not an owner and/or the spouse of an owner? ❑Yes ❑ No

Number of full-time employees (30 hours or more per week; including owner) _____

Number of part-time employees (less than 30 hours per week) _____

Quote # (from Group Proposal) _____

Certification and Disclosures

1. The company named above is a bona fide business and not in operation for the sole purpose of obtaining health insurance.
2. All enrollees are actively working for financial compensation and are covered by Worker's Compensation as required by law.
3. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
4. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
5. Payments not received by the 10th of the month are subject to a late fee, currently $25.
6. Payments not received by the 20th of the month are subject to a pending termination fee, currently $50.
7. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $50.
8. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $20.
9. Member firms must maintain good standing in their respective Business Association or Chamber of Commerce to participate in the group insurance programs offered through HSA Insurance.
10. HSA Insurance charges a monthly service fee per account.

HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
I certify that the information on this form is true and complete, that I understand and agree to the above administrative requirements, and that I have the legal authority to sign on the company's behalf.

Signature _____ Title _____ Date _____

Broker name (if applicable) _____
Address _____
City _____ State _____ ZIP _____

For office use only
Account representative _____

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Delta Dental of Massachusetts
GROUP CONTRIBUTORY PLANS- For 2 or more employees

Company Name: **Address:**	**Desired Effective Date:** (must be 1st of month)
Contact name: **Phone:** **Email:**	**Plan Selection** ☐ Delta Dental Premier 2+ Employees No Waiting period

ELIGIBILITY & PARTICIPATION REQUIREMENT

ELIGIBLE COMPANIES: A firm with 2 or more full time employees (with 2 or more enrolling) that maintains a membership with HSA
ELIGIBLE EMPLOYEES: All full-time employees working at least 30 hours per week
WAIVER: EE's covered on a spouse's family dental plan can be excluded; a Waiver Form must be completed
PARTICIPATION REQ: 70% of the eligible employees must be enrolled and must remain on the plan for a minimum of one year
EMPLOYER CONTRIBUTION: The employer must contribute at least 50% of the EE's premium
NEW HIRES: All eligible EEs can be enrolled within 30 days of hire or within time frame consistent with company new hire probation policy

ENROLLMENT INFORMATION

SIC Code (4 digits) [_____] **Nature of business:**	**Employer Contribution** (minimum 50%)	**Type of Business** ☐ Sole Proprietor ☐ Partnership ☐ Corporation

Eligibility Waiting Period*
None___ 1 Months___ 2 Months___ 3 Months___ 4 Months___ 5 Months___

*Definition: The period from the date of hire to the time a new employee is eligible to be added to the company health plan.

Total # of employees (including owners) _____
Subtract EEs covered by spouse's dental plan _____
Total # of Eligible EEs _____

The Effective date of coverage for new eligible employees is:
☐ The 1st of the month following satisfaction of waiting period
☐ The day the waiting period has been satisfied (i.e. one month from date of hire)

MONTHLY PREMIUM CALCULATION

Delta Dental Premier

Type of coverage	# of Elig EEs	X	Monthly Rate*	=	Premium
EE Only		x		=	
EE & Spouse		x		=	
EE & Child		x		=	
Full Family		x		=	
Service Fee	1	x	$5.00	=	$5.00
Total				=	
* Enter rates for your plan					

Signature (Authorized Employer Representative)	**Title**	**Date**

Broker Name (If Applicable)	**Agency Name, Address**	**Phone**	**Account Rep**

DELTA DENTAL

ENROLLMENT FORM

PLEASE PRINT OR TYPE -
BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT

HSA Insurance
135 Wood Road
Braintree, MA 02184
Tel.: 781-228-2222
Fax: 781-848-7020

1. GROUP NAME:	2. EFFECTIVE DATE	3. DATE OF HIRE	4. GROUP NUMBER

5. SOCIAL SECURITY NO.	6. LAST NAME (Subscriber)	7. FIRST NAME:	8. DOB:	9. SEX:

10. HOME ADDRESS:	11: CITY:	12. STATE:	13. ZIP

14. COMPANY NAME:	15. WORK PHONE:	16. HOME

PLAN SELECTION

17. PLAN ☐ Delta Dental Premier 2+ employees No Waiting Period

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

18. FIRST NAME	19. LAST NAME: (IF DIFFERENT FROM SUBSCRIBER)	20. DATE OF BIRTH	21. SEX M/F	22. CHECK IF DEPENDENT IS OVER 19 AND FULL TIME STUDENT	23. DELTACARE MEMBERS ONLY		
					Choose Provider for each covered individual	Porvider No.	Do you currenlty use this dentist?
SUBSCRIBER				☐			
SPOUSE				☐			
CHILDREN				☐			
				☐			
				☐			
				☐			

24. REASON FOR SUBMISSION (CHECK ONE)

☐ New Addition
☐ Individual ☐ Family
☐ Termination
☐ Add dependent to family
☐ Reinstatement
☐ Remove dependent _____(name)
☐ Name change
☐ Address change
☐ Remove dep. from student status _____ (name)

☐ Transfer from sublocation _____to _____
☐ Status change
☐ Individual ☐ Family
☐ COBRA
Reinstatement of Subscriber
☐ Individual ☐ Individual+1 ☐ Family
☐ Transfer to COBRA Sublocation _____
☐ New addition of dependent formerly covered under ID#_____

25. COORDINATION OF BENEFITS

Are ☐ you OR ☐ any other family member covered by another dental plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____ .

OTHER DENTAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DAY

26. Are ☐ you OR ☐ any other family member covered by another medical plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____ .

OTHER MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DAY

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental of Massachusetts. In addition, if my employer requires employee contribution for this coverage, I authorize the deduction of this amount from my wages.

Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____

HSAinsurance

Corporate Office
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Delta Dental
Waiver of Coverage Form

Company Name: _____

Employee Name: _____ Date of Birth: _____

Reasons for Waiving Dental Benefits (check one):

____ Covered through parent's Dental plan

____ Covered through spouse's employer's Dental plan

Employer name _____

Dental Carrier _____

_____ Other _____

_____

Employee Signature_____ Date _____

This form may be duplicated

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Electronic Payment Request Form

New Client? Pressed for time? Call (781) 228-2222 (8:30am-5:00pm, M-F) to quickly set up electronic payments. Just have your bank account and routing numbers ready. Or, complete this form:

Client Information:

Client Name: _____ Client Email: _____

New Client: Quote number and/or Application ID: _____

Current Client: 6 Digit HSA Account number: _____

Select payment type:

- ☐ **Recommended for new clients:** Withdraw both first month payment and recurring monthly payments
- ☐ First month payment only

If requesting recurring monthly payments, select date for withdrawal.

☐ 15th of the month ☐ 24th of the month

All outstanding balances owed, including fees, will be transferred at that time.

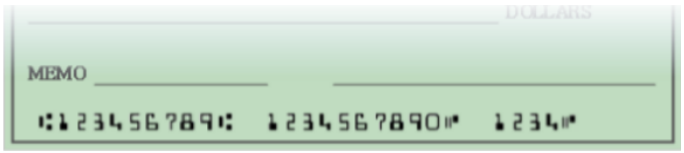
Bank Information:

Bank Name: _____ City: _____ State ____ Zip: _____

Name on Account: _____

Routing Number: _____ Bank Account Number: _____

Account Type: ☐ Checking ☐ Savings



Authorization:

I (we) hereby authorize HSA Insurance to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA Insurance has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. Note: all written debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Authorized Signer _____ _____

Sign Name Print Name and Title

Date: _____ Client Telephone: _____

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.