DELTA DENTAL®

Application for Small Group Dental Coverage
(2-50 enrolled employees)

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
800-627-3961 Fax 605-224-0909
www.deltadentalsd.com

Requested effective date _____

Group Information

Group name _____

Contact name _____ Contact phone _____

Street address _____ P.O. Box _____

City _____ State _____ Zip _____

E-mail address _____

Fax _____ Name of health insurance carrier _____

Plans and Payment (Rates are guaranteed until December 31)

Does the employer pay any portion of the employee rate? If so, what percentage? _____

Voluntary Plans
The employer pays less than 50% of the employee rate.

_____ Base #4030

_____ Standard #4040

_____ Enhanced #4050

_____ Premium #4060

Contributory Plans
The employer pays 50% or more of the employee rate.

_____ Base #5030

_____ Standard #5040

_____ Enhanced #5050

_____ Premium #5060

A four-rate structure is available for groups with 10+ enrolled employees or groups that have a medical plan with a four-rate structure. Do you want a 2 rate or a 4 rate four-rate structure? ___2 rate or ____4 rate

Employee $_____

Family $_____

or

Employee $_____

Emp/Sp $_____

Emp/Children $_____

Family $_____

Your monthly invoice will be available by logging on to Delta Dental's website. List the e-mail address you would like us to use to notify you when your invoice is ready. _____

Delta Dental accepts payment by electronic funds transfer. See the ACH form.

Employee Information

Total number of eligible employees _____ Total number of enrollment forms submitted _____

Waiting period: new employees will be eligible on the first day of the month following _____ month(s) of employment.

Terminated employees will be covered to the last day of the month.

Employees may not change coverage for any reason other than death, divorce, or marriage except at open enrollment, January 1.

Delta Dental will handle COBRA paperwork for employees at no extra charge unless we are notified otherwise.

ID cards will be sent to the employee.

Group Signature

I certify that the above information is true and correct. I agree to follow the requirements stated in this application. In the event such requirements are not adhered to, Delta Dental may terminate this policy.

Signed_____ Title_____

Name_____ Date_____

Broker Information

As the acting representative for this group, I have to the best of my knowledge complied with the requirements listed in this application.

Agent name _____ Agency name _____

Address _____ City, State and Zip _____

Phone_____ E-mail _____

Agent signature _____ Date _____

Group Authorization for Direct Payment via ACH

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
(605)224-7345 Fax (605)224-0909
(800)627-3961
www.deltadentalsd.com

Group name: _____ **Group #**: _____ **Loc #:** _____

Name: _____

Address: _____

City/State/Zip: _____ **Phone number**: _____

Email address: _____

Direct payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

Check one: ☐ Begin payment effective _____ ☐ Change information effective _____

I authorize Delta Dental of South Dakota to electronically debit my account and, if necessary, to electronically credit my account to correct erroneous debits. Funds will be drawn from your account on or around the 10th of each month.

Select one: ☐ Checking account or ☐ Savings account at the depository financial institution named below ("Depository"). I agree that ACH transactions I authorize comply with the laws of the United States and all applicable law.

Depository name: _____

Routing number: _____ **Account number**: _____

Name on the account: _____

I agree as the receiver of this authorized entry to be bound by the Nacha Operating Rules. I understand that this authorization will remain in full force and effect until I notify Delta Dental, in writing, that I wish to revoke this authorization.

Printed name: _____

Signature: _____ Date: _____