DELTA DENTAL®

Application for Pooled Group Dental Coverage

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
1-800-627-3961
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 _____

Employee Information

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

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

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.

Plan, Rates and Payment

Plan:

☐ 5-Plus #9000
☐ 10-Plus #9010
☐ 10-Plus with Orthodontics #9020
☐ 25-Plus #2500
☐ 25-Plus with Orthodontics #2525

Rates:

Single $_____

Family $ _____

Your monthly invoice will be available by logging on to Delta Dental's website. The e-mail address you would like to use so we can notify you that your invoice is ready: _____

Delta Dental only accepts payment by electronic funds transfer. A voided check from the account you would like us to withdraw from each month must be attached to this application.

Participation Requirements

- The employer must pay the full single cost for all eligible employees.
- 100% enrollment of all full-time employees who have satisfied the eligibility waiting period. Part-time employees may be included only if the employer pays the cost for all eligible part-time employees.
- Employees may not change coverage for any reason other than death, divorce or marriage except at open enrollment, January 1.
- Terminated employees are covered to the last day of the month in which they cease to be an eligible employee.
- New employees are eligible the first of the month after completion of the waiting period.
- Rates are guaranteed to December 31 from the effective date of coverage.

I certify that all of the above information is true and correct. I agree to abide by the participation requirements as set forth above. In the event such requirements are not adhered to, Delta Dental may terminate this policy.

Signed_____ Title_____

Name_____ Date_____

Agent Information

As the acting representative for the above group, I have to the best of my knowledge and ability complied with the participation requirements listed above.

Agent name _____ Firm name _____

Address _____City, State and Zip _____

Agent signature _____ Date _____