DELTA DENTAL®

Application for SD Retailers Association Group Dental Coverage

(must be a member of the SD Retailers Association)

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.

Rates and Payment

Rates:	8010 & 8012 Plans		8013 & 8015 Plans
Employee	$_____	Employee	$_____
Family	$_____	Employee/Spouse	$_____
		Employee/Children	$_____
		Family	$_____

The employer pays _____% of the single cost.

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 be a South Dakota Retailers Association member.
- The employer must pay at least 25% of the single cost for 8010 and 8013 plans and 50% of the single cost for the 8012 and 8015 plans.
- New employees are eligible the first of the month after completion of the waiting period.
- A minimum enrollment of 50% (for 8010 and 8013 plans) and 75% (for 8012 and 8015 plans) of all full-time employees who have satisfied the eligibility waiting period is required. Part-time employees may be included only if the employer pays for eligible part-time employees.
- Employees may not change coverage for any reasons other than death, divorce or marriage except at open enrollment in January.
- Terminated employees are covered to the last day of the month in which they cease to be an eligible employee.
- Rates are guaranteed to December 31.

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 _____