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

Voluntary Plans	Contributory Plans
______ Base #4030	______ Base #5030
______ Standard #4040	______ Standard #5040
______ Enhanced #4050	______ Enhanced #5050

Requested effective date ______________________
(must be 1st day of the month)

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 ______________________

Rates and Payment

Does the employer pay any portion of the single cost? If so, what percentage? ______________________

Voluntary Rates (Employer pays less than 50% of the single)	Contributory Rates (Employer pays more than 50% of the single)
Single $____________	Single $____________
Family $____________	Family $____________

A four-rate structure is available for groups with 10+ employees or groups that have a medical plan with a four-rate structure.

Rates are guaranteed until December 31.

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 accepts payment by electronic funds transfer. Please attach a voided check from the account you would like us to withdraw from each month.

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____

Agent 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 ___________________________