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

Voluntary Plans
☐ Base #4030
☐ Standard #4040
☐ Enhanced #4050

Contributory Plans
☐ Base #5030
☐ Standard #5040
☐ 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)

Single $_____

Family $_____

Contributory Rates
(Employer pays more than 50% of the single)

Single $_____

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 _____

Submit completed group applications by email to smallbusiness@deltadentalsd.com