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+ 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. 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 _____

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Enrollment/Change Form

Effective date: _____

Hire date: _____

Group name: _____ Group number: _____

Employee name: _____ SSN: _____

Mailing address: _____ DOB: _____

City/State/Zip: _____ Sex: ____M ____F

Cell phone* _____ Email:* _____

Marital status (common law marriage is not recognized in South Dakota): Single ___ Married ___

List only the names of dependents you are enrolling. I understand that should I decide to apply for single coverage, even though I am eligible for family coverage, I cannot change my policy until open enrollment or a qualifying event (within the past 30 days). I also understand that Delta Dental of South Dakota reserves the right to reject a change form.

First Name Last Name Gender Date of Birth

☐Add
☐Drop Spouse _____

Cell phone* _____ Email* _____

☐Add
☐Drop Child _____

Cell phone* _____ Email* _____

☐Add
☐Drop Child _____

Cell phone* _____ Email* _____

☐Add
☐Drop Child _____

Cell phone* _____ Email* _____

☐Add
☐Drop Child _____

Cell phone* _____ Email* _____

Use an additional sheet if you have more dependents. List dependents you want removed from your plan in the space provided above.

Change in coverage

Marriage date: _____ Divorce date: _____

Other (explain): _____ Date of change: _____

Signature: _____ Date: _____

I accept the insurance provided by my employer's group dental plan and authorize deductions from my earnings for the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required. I understand that by accepting insurance, I am required to remain enrolled as a covered employee until the next open enrollment period, a qualifying event, or until the termination of my employment.

*I consent to Delta Dental using this information for quality improvement activities (surveys) for individuals over 18. Email and text messages sent from Delta Dental may not be sent in an encrypted or secure manner.