



Application for small group Dental and Vision 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

Please email completed application (pages 1-4) to sales@deltadentalsd.com

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 _____

Broker 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 _____

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 and/or Wellness 605 Inc. may terminate this policy.

Signed _____ Title _____
Name _____ Date _____



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 _____

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+ enrolled employees or groups that have a medical plan with a four-rate structure. Do you want a 2 rate or a 4 rate structure? ____2 rate or ____4 rate

Employee	\$ _____		Employee	\$ _____
Family	\$ _____	OR	Emp/Spouse	\$ _____
			Emp/Children	\$ _____
			Family	\$ _____

Your monthly invoice will be available by logging on to Delta Dental's website. List the e-mail address you would like us to use to notify you when your invoice is ready. _____

Delta Dental accepts payment by electronic funds transfer. See the ACH form.

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.



Application for Small Group Vision Group (2-50 enrolled employees)

Coverage by Wellness 605, Inc.

720 N Euclid Ave, Pierre, SD 57501
800-627-3961 Fax 605-224-0909
www.deltadentalsd.com

Requested effective date _____

Plans and Payment (Rates are guaranteed until December 31)

Does the employer pay any portion of the employee cost? If so, what percentage? _____

Voluntary Plans

(Employer pays less than
50% of the employee rate)

_____ Essential Plan 2

_____ Classic Plan 5

_____ Supreme Plan 16

Contributory Plans

(Employer pays more than
50% of the employee rate)

_____ Essential Plan 2

_____ Classic Plan 5

_____ Supreme Plan 16

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

Employee \$ _____

Employee \$ _____

Family \$ _____ OR

Emp/Spouse \$ _____

Emp/Children \$ _____

Family \$ _____

Your monthly invoice will be available by logging on to DDSD's website. List the e-mail address you would like us to use to notify you when your invoice is ready: _____

We accept payment by electronic funds transfer. See the attached ACH form.

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.

DeltaVision® is offered in partnership with EyeMed and underwritten by Wellness 605, Inc., a wholly owned subsidiary of Delta Dental of South Dakota (DDSD). DeltaVision and Delta Dental are registered marks of Delta Dental Plans Association. Wellness 605, Inc. contracts with DDSD for certain billing and administrative matters.

Terminated employees will be covered until 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 of South Dakota will handle COBRA paperwork on behalf of Wellness 605, Inc. for separating employees at no extra charge unless we are notified otherwise. ID cards will be sent to the employee.



Group Authorization for Direct Payment via ACH Dental and Vision

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
800-627-3961 Fax 605-224-0909
www.deltadentalsd.com

☐ Dental ☐ Vision

Group name: _____ Group #: _____ Loc #: _____

Name: _____

Address: _____

City/State/Zip: _____ Phone number: _____

Email address: _____

Direct payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment.

Check one: ☐ Begin payment effective _____ ☐ Change information effective _____

I authorize Delta Dental of South Dakota and/or Wellness 605, Inc. to electronically debit my account and, if necessary, to electronically credit my account to correct erroneous debits. Funds will be drawn from your account on or around the 10th of each month.

Select one: ☐ Checking account or ☐ Savings account at the depository financial institution named below ("Depository"). I agree that ACH transactions I authorize comply with the laws of the United States and all applicable law.

Depository name: _____

Routing number: _____ Account number: _____

Name on the account: _____

I agree as the receiver of this authorized entry to be bound by the Nacha Operating Rules. I understand that this authorization will remain in full force and effect until I notify Delta Dental and/or Wellness 605, Inc., in writing, that I wish to revoke this authorization.

Printed name: _____

Signature: _____ Date: _____

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