Application for Small Group Affordable Care Act Dental Plans

☐ Standard Option #602

☐ Enhanced Option #603

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 _____ 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

Age 0-20 $_____

Age 21-34 $_____

Age 35-49 $_____

Age 50-63 $_____

Age 64+ $_____

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. Please attach a voided check from the account you would like us to withdraw from each month.

Participation Requirements

- Employees may not change coverage for any reason other than death, divorce or marriage except at open enrollment, January 1.
- Terminated employees are covered to the last day of the month in which they cease to be an eligible employee.
- New employees are eligible the first of the month after completion of the waiting period.
- 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 _____ Agency _____

Address _____ City, State and Zip _____

Agent signature _____ Date _____