Application for Voluntary Group Dental Coverage

______ #9050 Voluntary I

______ #9060 Voluntary II

______ #9070 No Minimum Voluntary

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 ____________________

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 _______ complete 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

Single $_____________

Family $_____________

Does the employer pay any portion of the single cost? If so, what percent? __________________

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. A voided check from the account you would like us to withdraw from each month must be attached to this application.

Participation Requirements

- Minimum participation:
  Voluntary I #9050 - minimum of 2 employees
  Voluntary II #9060 - minimum of 10 employees
  No Minimum Voluntary #9070 – minimum of 2 employees
- No employer contribution is required for any of these plans.
- New employees are eligible the first of the month after completion of the employer's waiting period.
- Rates are guaranteed to December 31.
- 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.

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 name ______________________ Agency name ______________________

Address ______________________ City, State and Zip ______________________

Phone______________________ E-mail ______________________

Agent signature ______________________________ Date ______________