DELTA DENTAL

2009 Group Dental Application

Community-Rated Programs

10 - 200 Enrolled Employees

Section 1	GROUP INFORMATION: (Please Type or Print Legibly)		
Group Name: (Please do not abbreviate)		**Phone:**	**Fax:**
Address:		**E-mail Address:**	
City:	**State:**	**Zip Code:**	**Type of Business:**
Primary Contact:		**SIC Code:**	

Receive monthly billings via Web Retrieval? ☐ Yes ☐ No

Would you like information about on-line eligibility? ☐ Yes ☐ No

There is no need to attach a binder check. Delta Dental of Kansas will bill the group.

Would you like DDKS to bill individuals for COBRA? ☐ Yes (attach signed billing designation) ☐ No

Billing Address (*if different than above*):	**Billing Contact:**

Section 2 PLAN DESCRIPTION:

Effective Date: ____/1/2009

Number of Enrolled Employees:

Eligible Employees:

Circle choice of each of the following:

Rate Tier:	2	3	4	
Base Plan:	1	2	3	4
Network:	Premier	PPO	EPO	

Base Monthly Premium

Employee	$ _____
E + ____	$ _____
E + ____	$ _____
Family	$ _____

Additional Monthly Premium for Optional Benefits

	Orthodontics		$1500 Max		$25 or $50 Deductible		Posterior Composites:		TOTAL PREMIUM
Employee	N/A	+	$_____	+	$_____	+	$_____	=	$ _____
E + _____	$_____	+	$_____	+	$_____	+	$_____	=	$ _____
E + _____	$_____	+	$_____	+	$_____	+	$_____	=	$ _____
Family	$_____	+	$_____	+	$_____	+	$_____	=	$ _____

Contract Provisions

Waiting Period for new hires:

First day of the month following:

- ○ 30 days
- ○ 60 days
- ○ 90 days

Deductible is :

- ○ $25 x 3
- ○ $50 x 3
- ○ $75 x 3

Deductibles and maximums are calendar year only.

Plans with orthodontics only

Was orthodontics covered under prior plan? _____

If yes, name of carrier: _____

When did/will prior coverage terminate? _____

Orthodontics lifetime maximum is $1000

Agent of Record (*If applicable*)

Agent: _____

Agency: _____

Agent Phone Number: _____

Agent Email Address: _____

City: _____ State: _____ Zip Code: _____

Agent Signature: _____

Section 3 SIGNATURE / AUTHORIZATION

The applicant acknowledges that they have selected this plan based upon written information provided by Delta Dental of Kansas and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan document, specifically known as the Agreement to Provide Dental Benefits. This plan document will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan. I hereby apply for coverage indicated above. I certify that all information provided in this application is accurate and complete to the best of my knowledge and belief. By my signature below I agree to be bound by the terms and conditions of the plan document. I understand that Delta Dental of Kansas may choose not to accept this application at its sole discretion. I designate the above named broker as my agent of record to act on my behalf.

Company Representative's Signature: _____ Date: _____

Printed Name of Company Representative: _____ Title: _____