DELTA DENTAL

2010 Group Dental Application

Community Rated Programs

KANSAS ONLY

2 - 9 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:**	
	KS			
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.

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

Section 2 — PLAN DESCRIPTION: Choose Plan Design and Rate Tier

Effective Date: _____/1/2010	**Eligible Employees:**	**Enrolled Employees:**

PREMIER NETWORK PLANS

Check Plan Choice and Rate Tier			Plan	Plan		Annual	Two-Tier		Three-Tier		
Plan Choice	Rate Tier		Number	Benefits	Deductible	Maximum	E	Fam	E	E+1	Fam
○	○ 2	○ 3	21005	100/50/50	0	1000	37.02	103.30	37.02	71.63	117.04
○	○ 2	○ 3	21305	100/80/50	25 x 3	1000	42.32	119.16	42.32	81.61	135.54
○	○ 2	○ 3	21405	100/80/50	50 x 3	1000	39.89	113.49	39.89	76.83	129.49
○	○ 2	○ 3	21409	100/80/50	50 x 3	1500	45.08	128.24	45.08	86.82	146.32
○	○ 2	○ 3	21705	50/50/50	0	1000	26.03	67.35	26.03	50.39	74.82
○	○ 2	○ 3	21905	100/50/50	50 x 3	1000	32.07	91.93	32.07	62.11	104.86

PROFESSIONAL SERVICES

Check Plan Choice and Rate Tier			Plan	Plan		Annual	Two-Tier		Three-Tier		
Plan Choice	Rate Tier		Number	Benefits	Deductible	Maximum	E	Fam	E	E+1	Fam
○	○ 2	○ 3	21455	100/80/50	50 x 3	1000	47.09	133.89	47.09	90.68	152.73
○	○ 2	○ 3	21755	50/50/50	0	1000	30.76	79.54	30.76	59.52	88.30
○	○ 2	○ 3	21955	100/50/50	50 x 3	1000	37.93	108.68	37.93	73.45	123.94

PPO NETWORK PLANS

○	○ 2	○ 3	PPO 21565	100/80/50 80/60/40 out of network	75 x 3	1000	29.85	86.76	29.85	57.41	99.62
○	○ 2	○ 3	EPO 21665	100/80/50 00/00/00 out of network	75 x 3	1000	28.56	82.45	28.56	54.96	94.52

All plans include coverage for white resin composite fillings on all teeth

Contract Provisions	**Agent of Record (*If applicable*)**
Waiting Period for new hires:	Agent:
First of the month following ○ 30 days	Agency:
○ 60 days	Agent Phone Number:
○ 90 days	Agent Email Address:
	City: State: Zip:
Deductibles and maximums are calendar year	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: _____