DELTA DENTAL®

APPLICATION FOR A DENTAL CONTRACT

Delta Dental of New York, Inc.
Administrative Offices
One Delta Drive, Mechanicsburg, PA 17055
(800) 471-7091 TTY/TDD (888)373-3582

APPLICANT INFORMATION	Group Number:	Division(s):	
Name of Applicant:			Nature of Business:
Address:			
City:	State:	Zip: -	County:

CONTRACT TERM: From: 04/01/15 Through: 11/30/16 Contract Length: ___ months

NETWORK TYPE:

- ☐ Delta Dental Premier ®
- ☐ Delta Dental PPO
- ☐ Delta Dental PPO Plus Premier
- ☐ DeltaCare ® USA
- ☐ Flexible Dual Choice:
  - ☐ Annual
  - ☐ Monthly

DEPENDENT COVERAGE:

- ☒ Spouse
- ☒ Children to age 26 Standard — Exact Day
- ☒ Students to age 26 Standard — Exact Day
- ☒ Ortho to age 19 Standard — Exact Day
- ☐ Domestic Partners
- ☐ Domestic Partner Dependents

FREQUENCY LIMITATIONS:

Exams:	Twice in any Calendar Year period
Prophylaxes:	Twice in any Calendar Year period
Fluoride:	Twice in any Calendar Year period
Bitewing x-rays:	Twice in any Calendar Year period

COORDINATION OF BENEFITS:

- ☒ Regular
- ☐ Non-Duplication
- ☐ No Internal COB
- ☐ Primary for Impactions

BENEFITS TURNOVER PERIOD:

- ☒ Calendar Year
- ☐ Contract Year (to)

LIMITATIONS OR EXCLUSIONS UNDER ADDITIONAL RIDERS (Attach additional page if necessary)

Enhanced Benefits for Pregnancy ☒ Yes ☐ No

Group purchased Implant coverage as part of Prosthodontic coverage: ☒ Yes ☐ No

SERVICES	PPO	Premier	OON	SERVICES	PPO	Premier	OON
Diagnostic	100%	80%	80%	Adult Orthodontics	0%	0%	0%
Preventive	100%	80%	80%	Posterior Composites	%	%	%
Basic Restorative	80%	60%	60%	Denture Repair	50%	50%	50%
Major Restorative	50%	50%	50%	Denture Relining	50%	50%	50%
Oral Surgery	80%	60%	60%	Crown Repair	50%	50%	50%
Endodontic	80%	60%	60%	Crown Recementation	50%	50%	50%
Periodontic (*Surgical*)	80%	60%	60%	Bridge Repair	50%	50%	50%
Periodontic (*Non-Surgical*)	80%	60%	60%	Bridge Recementation	50%	50%	50%
Prosthodontic	50%	50%	50%		%	%	%
Orthodontic	50%	50%	50%		%	%	%
Sealants	100%	80%	80%		%	%	%
TMJ	50%	50%	50%		%	%	%

DEDUCTIBLE(S)					**MAXIMUM(S)**				
	PPO	**Premier**	**OON**	**Based on:**		**PPO**	**Premier**	**OON**	**Based on:**
Per Enrollee	$ 50	$ 75	$ 75	Calendar Year	Per Enrollee	$ 1500	$ 1000	$ 1000	Calendar Year
Per Family	$ 150	$ 225	$ 225	Calendar Year	Per Family	$	$	$	
Orthodontics	$	$	$		Orthodontics	$	$	$	

Services Exempt from the Deductible:

- ☒ Diagnostic & Preventive ☒ Sealants ☐ Orthodontics
- ☐ Other:

Services Exempt from the Maximum:

- ☐ Diagnostic & Preventive ☐ Sealants ☐ Other:
- ☐ Other:

CENSUS INFORMATION:

Total Number of Employees: _____
Number of Employees Eligible: _____
Number of Single: _____
Number of Two-Party: _____
Number of Three-Party+: _____

EMPLOYER CONTRIBUTION:

_____% Employees
_____% Dependents

REQUIRED PARTICIPATION:

75% Employees
50% Dependents

RATES: Monthly per Employee Type:

	1st Year	
Single:	$ _____	$ _____
Two-Party:	$ _____	$ _____
Three-Party+:	$ _____	$ _____
Family:	$ _____	$ _____
Composite:	$ _____	$ _____

RATING METHOD:

☒ Prospective
☐ Cost Plus
☐ Retention
☐ ASO/ERISA
Prefund: $

ADMINISTRATION OR RETENTION FEE:

☐ % of claims ☐ % of premium
☐ $ per employee per month

Settlement: Claims: by
Fee: by

ELIGIBILITY INFORMATION:

New Hire Eligibility: ☐ **DOH**
First of month following: ☐ **date of hire;**
_____ days of employment.

Additions: Standard

Terminations: Standard — End of Month

BROKER / CONSULTANT INFORMATION (if applicable)

Company Name:		
Address:		
City:	State:	Zip: -
Contact Person:	Title:	
E-mail Address:	Phone: ( ) -	Fax: ( ) -
Commission Amount:	Commission Payable To:	

SPECIAL REQUESTS (Attach additional page if necessary)

Medical Carrier _____

Application is herewith made for a dental service contract from Delta Dental of New York, Inc. (Delta). It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. It is further understood that Delta underwriting criteria for this contract requires at least 75% of eligible employees and 50% of employees with dependents must enroll. Any variance in this criteria must be approved by Delta prior to acceptance of the program. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

Dated on _____ Name of Applicant _____

By _____

Witness _____

Soliciting Agent _____

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Delta Dental of New York, Inc.
Small Business Program

SUPPLEMENT TO GROUP APPLICATION

APPLICANT INFORMATION		
Applicant's Name:	EIN:	4-digit SIC code:
State where company is headquartered:		
Will this Delta Dental program replace existing dental coverage currently through another dental plan? ☐ No ☐ Yes, name of carrier:	Number of Employees Participating in DeltaCare® USA Program: Total Enrollees:	

CONTACT PERSON INFORMATION			
Contact Person:	Title:		
Contact Phone: ( ) -	Contact Email:		
Contact Fax Number: ( ) -			
Billing address (if different from Applicant):	City:	State:	Zip:

DUAL CHOICE AND ENROLLMENT INFORMATION	
Dual Choice with a DeltaCare USA Program? (Y/N):	Minimum for Enrollment: 5 Primary Enrollees

DELTACARE USA PROGRAM (check one)		
☐ Plan 13A	☐ Plan 15A	☐ Plan M73 (not available in NY state)

EMPLOYER CONTRIBUTIONS (check one)		
☐ 0% - 49.9%	☐ 50% - 74.9%	☐ 75% - 100%

DELTACARE USA RATES (complete the following if client applying for DeltaCare USA)		
Enrollee Only:	(# of enrollees) x $	monthly premium rates) = $ 0.00
Enrollee & 1 Dependent:	(# of enrollees) x $	monthly premium rates) = $ 0.00
Enrollee & Family:	(# of enrollees) x $	monthly premium rates) = $ 0.00
		= $ 0.00

BROKER (WRITING AGENT) INFORMATION	
Name:	
Company name:	Company is incorporated? (Y/N):
Tax ID or SSN:	State & State License #:

GENERAL AGENT ("GA") INFORMATION – OFFICE USE ONLY
GA COMPANY NAME:
GA SALES REPRESENTATIVE:
☐ LEVEL ONE ☐ LEVEL TWO