

## Application for Group Dental Coverage

Group acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance.

The applicant must be domiciled in Illinois or have a bona fide situs in Illinois.

Groups and/or brokers/consultants are required to complete all applicable sections of this application.

Application will be considered after Delta Dental of Illinois receives:

- A completed group application form.
- A deposit check for the first month's premium for fully insured groups or the receipt of the prefund or arrangements for weekly ACH for self-funded groups.
- Completed enrollment forms. (For those waiving coverage, enrollment forms must be submitted and must indicate that coverage is waived.) Enrollment forms may not be required if another eligibility reporting method is arranged in advance.



## EMPLOYER/GROUP INFORMATION

**REQUESTED EFFECTIVE DATE OF COVERAGE:** \_\_\_\_\_

(Month, Date, Year)

Employer/Group: \_\_\_\_\_  
(Specify the legal name of the employer, the Taft-Hartley trust or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below. AN EMPLOYEE/GROUP BENEFIT PLAN MAY NOT BE NAMED).

Contracting Address: \_\_\_\_\_  
Street P.O. Box City State Zip

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Group Administrator: \_\_\_\_\_ Title: \_\_\_\_\_  
(Authorized Person)

Administrator Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer Tax Identification Number: \_\_\_\_\_

## BROKER/CONSULTANT INFORMATION

Broker/Consultant Name: \_\_\_\_\_ Agency/Firm Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street P.O. Box City State Zip

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

## EMPLOYER/GROUP AGREEMENT

The undersigned certifies that s/he is authorized to apply for coverage for the selected group dental program on behalf of the named group ("applicant") and to sign this application.

In making this application to Delta Dental of Illinois for the selected group dental coverage, the applicant agrees and understands that this application will become part of the Contract/Administrative Services Contract executed by an authorized officer of Delta Dental of Illinois. The applicant represents that all the information contained in this application is true and correct. *Misrepresentation of submitted data contained in this application will cause the contract to be null and void.*

It is agreed that the coverage requested is subject to the approval of Delta Dental of Illinois and that no agent or representative has authority to make or modify this application for coverage. Once approved by Delta Dental of Illinois, the applicant understands that coverage will not be effective until the required premium/funding and eligibility data, in a format agreed to by the parties, have been received.

**FOR FULLY INSURED CONTRACTS ONLY:** The applicant further understands that the rates quoted under the selected program are based upon meeting and maintaining the eligibility requirements and should participation fall below those requirements, Delta Dental of Illinois, at its discretion, may re-rate or terminate the account.

**FOR ASC/SELF INSURED CONTRACTS ONLY:** The group agrees to fully underwrite the risk of the selected group dental plan and accept liability for payment of benefits.

I certify that the applicant has met all requirements contained in this application.

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

