

# NEW GROUP IMPLEMENTATION SUMMARY

## 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).

Subsidiaries/Affiliated Companies, if applicable: \_\_\_\_\_  
(Legal Name)

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

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

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

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

Billing Contact: \_\_\_\_\_ Billing Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(If different than above)

Billing Contact E-mail: \_\_\_\_\_ Billing Address: \_\_\_\_\_  
(If different than above) (If different than above)

Eligibility/Enrollment Contact: \_\_\_\_\_ Eligibility/Enrollment Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(If different than above)

Eligibility/Enrollment Contact E-mail: \_\_\_\_\_

Prior Dental Carrier: \_\_\_\_\_

## ELIGIBILITY INFORMATION

Eligible person means (check all that apply):

- A full-time employee of the contracting employer who is regularly scheduled to work a minimum of \_\_\_\_\_ hours per week and who is on the permanent payroll of the employer.
- A full-time employee of the contracting employer who is enrolled in the employer's medical or dental plan. An employee's coverage shall terminate if s/he is no longer enrolled in the employer's medical plan. Coverage of an employee's dependents shall also terminate at this time.
- A full-time member of the contracting union or association.
- Domestic partners. (Please attach the employer's or group's definition of domestic partner.)
- Retirees. (Please attach the employer's or group's definition of a retiree.)
- Other: \_\_\_\_\_

Total number of eligibles \_\_\_\_\_ Total number of enrollees \_\_\_\_\_ Total number of waivers \_\_\_\_\_



## ELIGIBILITY INFORMATION (continued)

### **Delta Dental PPO/Delta Dental Premier®**

New hire eligibility date:

- On the date of employment.
- Following \_\_\_\_ days of employment.
- On the first of the month following the date of employment.
- On the first of the month following \_\_\_\_ days of employment.
- Other: \_\_\_\_\_

Termination (Coverage for an employee who ceases to meet the definition of eligible person is terminated):

- On the date such person ceases to meet the definition of eligible person.
- The last day of the calendar month in which such person ceases to meet the definition of eligible person.

Limiting Age:

The limiting age for covered unmarried dependent children is \_\_\_\_; and \_\_\_\_ if a full-time student.

- Coverage is terminated on the birthday.
- Coverage is terminated on the last day of the calendar month in which the limiting age is reached.

The student age extension applies to orthodontic benefits.  Yes  No

### **DeltaCare® Dental HMO (if applicable)**

New hire eligibility date:

- On the first of the month following the date of employment.
- On the first of the month following \_\_\_\_ days of employment.

Termination (Coverage for an employee who ceases to meet the definition of eligible person is terminated):

On the last day of the calendar month in which such person ceases to meet the definition of eligible person.

Limiting Age:

The limiting age for covered unmarried dependent children is \_\_\_\_; and \_\_\_\_ if a full-time student.

Coverage is terminated on the last day of the calendar month in which the limiting age is reached.

## FUNDING INFORMATION

The employer contributes:

\$ \_\_\_\_\_ or \_\_\_\_% of the cost of the employee's insurance.

\$ \_\_\_\_\_ or \_\_\_\_% of the cost of one or more dependents' insurance.

## PLAN SPECIFICS

Benefits Accumulation:  Contract Year  Calendar Year  Other \_\_\_\_\_

Deductible & Maximum Accumulation:  Contract Year  Calendar Year  Other \_\_\_\_\_



## MONTHLY PREMIUM RATES — FULLY INSURED

### *Delta Dental PPO/Delta Dental Premier*

**(DO NOT INCLUDE ANY DELTACARE DENTAL HMO ENROLLEES; PLEASE SEE DELTACARE SECTION.)**

Single Dental Rate	\$
Single + Spouse OR Single + Dependent Dental Rate	\$
Single + Child(ren) Dental Rate	\$
Single + Family Dental Rate	\$

1-year rate    2-year rates    3-year rates

### *DeltaCare Dental HMO, if applicable*

Single Dental Rate	\$
Single + Spouse OR Single + Dependent Dental Rate	\$
Single + Child(ren) Dental Rate	\$
Single + Family Dental Rate	\$

1-year rate    2-year rates    3-year rates

Binder Amount: \$ \_\_\_\_\_ Wire Transfer \_\_\_\_\_ Check \_\_\_\_\_

If group has multiple locations, does group require summary billing?    Yes    No

## ADMINISTRATIVE FEE

The group agrees to pay Delta Dental of Illinois monthly \$ \_\_\_\_\_ per employee per month for \_\_\_\_\_ months.

Prefund Amount: \$ \_\_\_\_\_ Wire Transfer \_\_\_\_\_ Check \_\_\_\_\_

-OR-

Weekly Payment: \_\_\_\_\_ ACH Debit\*   \_\_\_\_\_ Wire Transfer

Note: If group opts to pay weekly, administrative fees will be added to the last funds transfer of the month.

\*If ACH Debit, please supply banking information:

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

Account Number: \_\_\_\_\_ Routing Information: \_\_\_\_\_

Weekly report recipient(s): \_\_\_\_\_

## MONTHLY BILLING DELIVERY METHOD

\*Please complete if applicable.

\_\_\_\_\_ E-mail/Online Billing   \_\_\_\_\_ Fax   \_\_\_\_\_ Other: \_\_\_\_\_

## ONLINE BILLING/ENROLLMENT

\*Please complete if applicable.

Designated Super User for Online Dental Billing: \_\_\_\_\_

Designated Super User for Online Dental Enrollment: \_\_\_\_\_

Group Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

