

Application for Group Dental Coverage

Delta Dental of Illinois is unable to accept this document with any changes, cross-outs, white-outs, etc., unless the person signing the application initials those changes. 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. The policy and premium statements will only be issued to this Illinois address.

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.
- A copy of the proposal outlining the selected benefits or a group benefit form.
- 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).

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 Contact: _____ Eligibility Contact Phone: (____) _____ - _____
(If different than above)

Eligibility Contact E-mail: _____

Nature of Business: _____ Years in business: _____ SIC Code: _____
(If manufacturing, please specify principal type of product and material used.)

Type of Ownership: Sole-Proprietorship Partnership Corporation

Employer Tax Identification Number: _____ Employer Plan Number: _____

CURRENT DENTAL/HEALTH CARRIER INFORMATION

Current dental carrier: _____ Address: _____
(Please attach a copy of the following from your current carrier: 1) Current monthly bill, 2) Description of current coverage (i.e. brochures, certificates, etc.)

Current health carrier: _____ Effective date: _____
Address: _____

BROKER/CONSULTANT INFORMATION

Broker/Consultant Name: _____ Agency Name: _____

Address: _____
Street P.O. Box City State Zip

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Email: _____



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

ELIGIBILITY INFORMATION

Eligible person means:

A full-time employee of the contracting employer who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the employer.

Total number of eligible _____ Total number of enrollees _____ Total number of waivers _____

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 _____ days of employment.
 30 days
 60 day
 90 day

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.

Delta Dental of Illinois plan option chosen (please attach copy of quote)

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 + Family Dental Rate	\$

DeltaCare Dental HMO, if applicable

Single Dental Rate	\$
Single + Spouse OR Single + Dependent Dental Rate	\$
Single + Family Dental Rate	\$



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.

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

Name: _____

Title: _____ Date: _____

Signature: _____

