

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 _____

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: _____

If group has multiple locations, does group require summary billing? (Fully insured groups only) ___ Yes ___ No

*Summary Billing includes a summary that lists actual enrollees, prior balance, retro adjustments, current billed and total due by each location with a grand total for all locations.

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: _____

