

NEW GROUP IMPLEMENTATION SUMMARY

EMPLOYER/GROUP INFORMATION

Requested Effective Date of Coverage: _____ SIC# _____
(Month, Date, Year)

Employer/Group: _____
(Specify the legal name, the Taft-Harley trust or the association applying for coverage.)

Subsidiaries/Affiliated Entities, if applicable: _____
(Legal Name)

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

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

Group Administrator: _____ Title: _____
(Authorized Person)

Phone: (____) ____ - _____ Email: _____

ADDITIONAL CONTACT INFORMATION

If different than Group Administrator:

Billing Contact: _____ Phone: (____) ____ - _____

Email: _____ Address: _____

If different than Billing Contact:

Enrollment Contact: _____ Phone: (____) ____ - _____

Email: _____ Address: _____

PLAN SPECIFICS

Deductible & Maximum Accumulation: Contract Year Calendar Year Other: _____

EMPLOYER CONTRIBUTIONS

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

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

Total number of eligibles: _____

Total number of enrollees: _____

ELIGIBILITY INFORMATION

Eligible person means (check all that apply):

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

A full-time employee enrolled in the medical plan. An employee's coverage shall terminate if s/he is no longer enrolled in the medical plan.

A full-time member of the contracting union or association.

Domestic partners:

Same sex Opposite sex Both

Are dependents of Domestic Partners covered?

Yes No

Are Domestic Partners covered under group medical plan?

Yes No

Please use the following definition:

Delta Dental standard (see below) Medical (please attach)

"Domestic Partner" means an individual of (the same and/or opposite) sex of the subscriber and for whom the subscriber has completed and signed a Declaration of Domestic Partnership. The Declaration must be acceptable to the group subscriber.

Retirees:

Retiree age is: _____

Are dependents of Retirees covered?

Yes No

Please use the following definition:

Delta Dental standard (see below) Medical (please attach)

"Retiree" means a person retired from the active service of the employer and covered under this Group Dental Plan immediately prior to retirement.

Other: _____

PPO/Premier®

New Hire Eligibility Date:

Following _____ days of employment. On the first of the month following _____ days of employment Date of hire

Other: _____

Termination Occurs On:

Date employee ceases to be eligible Last day of the calendar month in which employee ceases to be eligible

Limiting Age:

Fully Insured: The limiting age for covered unmarried dependent children is 26.

Self Funded: The limiting age for covered unmarried dependent children is _____; and _____ if a full-time student.

Dependent Children coverage is terminated on: Birthday Last day of the calendar month in which the limiting age is reached

Prior Carrier: _____

DHMO/DeltaCare

New Hire Eligibility Date: On the first of the month following _____ days of employment.

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

Prior Carrier: _____

MONTHLY BILLING DELIVERY INFORMATION

Email/Online Billing Fax Other: _____

Summary Billing includes a summary of enrollees, prior balance, adjustments, current billed & total due by location with a grand total for all locations. If group has multiple locations, does the group require **Summary Billing**? (Fully insured groups only.) Yes No

MONTHLY PREMIUM RATES – Fully Insured

Binder Amount: \$ _____ Wire Transfer Check

PPO/Premier®

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

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

DHMO/DeltaCare

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

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

X _____

Authorized Signature (Your signature confirms your acceptance of the rates listed above.)

ADMINISTRATIVE FEE – Self Funded

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

***If ACH Debit, please supply banking information:**

Bank Name: _____

Account Number: _____ Routing Information: _____

X _____

Authorized Signature (Your signature confirms your acceptance of the fees listed above.)