

# NEW GROUP IMPLEMENTATION SUMMARY (RISK & ASC)

## EMPLOYER/GROUP INFORMATION

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

Employer/Group: \_\_\_\_\_  
(Specify the legal name, 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 Code

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

## PLAN SPECIFICS

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

## EMPLOYER CONTRIBUTIONS FOR DENTAL

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

Total number of eligibles: \_\_\_\_\_ Total number of enrollees: \_\_\_\_\_

## EMPLOYER CONTRIBUTIONS FOR DELTAVISION®

The **employer** contributes:

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

\_\_\_\_\_ % or \$ \_\_\_\_\_ of the cost of one dependent's (3-tier rates) or spouse's (4-tier rates) vision insurance

\_\_\_\_\_ % or \$ \_\_\_\_\_ of the cost of child(ren) (4-tier rates) vision insurance

\_\_\_\_\_ % or \$ \_\_\_\_\_ of the cost of family vision insurance

Total number of eligible employees: \_\_\_\_\_ Total number of eligible family units: \_\_\_\_\_

Are all full-time employees eligible for this plan?  Yes  No

If no, please specify any classes not eligible: \_\_\_\_\_

Number of eligible employees not working at the above address: \_\_\_\_\_ Please specify location(s): \_\_\_\_\_



## 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

### 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: \_\_\_\_\_

## Delta Dental PPO<sup>SM</sup>/Delta Dental Premier<sup>®</sup>

### 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:** \_\_\_\_\_

## DeltaCare (DHMO)

**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:** \_\_\_\_\_



## DeltaVision®

Group Vision Coverage     Group Voluntary Coverage

Is the eligibility the same for DeltaVision as for the dental program?     Yes     No    If no, please specify eligibility requirements for the vision program: \_\_\_\_\_

Is the employer contribution the same for DeltaVision as for the dental program?     Yes     No    If no, please specify employer contributions for the vision program: \_\_\_\_\_

### 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:** \_\_\_\_\_

\*Please Note: DeltaVision® is provided by TruAssure Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

## MONTHLY BILLING DELIVERY INFORMATION

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

**Summary Billing** includes a summary of enrollees, prior balance, adjustments, current billed and 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

### Delta Dental PPO<sup>SM</sup>/Delta Dental Premier<sup>®</sup>

Single Dental Rate	\$
Single + Spouse OR Single + Dependent Dental Rate	\$
Single + Child(ren) Dental Rate	\$
Single + Family Dental Rate	\$
<input type="checkbox"/> 1-year rate <input type="checkbox"/> 2-year rates <input type="checkbox"/> 3-year rates Rates guaranteed from _____ to _____.	

### DeltaCare (DHMO)

Single Dental Rate	\$
Single + Spouse OR Single + Dependent Dental Rate	\$
Single + Child(ren) Dental Rate	\$
Single + Family Dental Rate	\$
<input type="checkbox"/> 1-year rate <input type="checkbox"/> 2-year rates <input type="checkbox"/> 3-year rates Rates guaranteed from _____ to _____.	

### DeltaVision<sup>®</sup>

Single Vision Rate	\$
Single + Spouse OR Single + Dependent Vision Rate	\$
Single + Child(ren) Vision Rate	\$
Single + Family Vision Rate	\$
<input type="checkbox"/> 1-year rate <input type="checkbox"/> 2-year rates <input type="checkbox"/> 3-year rates Rates guaranteed from _____ to _____.	

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 for *dental* monthly \$ \_\_\_\_\_ per employee per month for \_\_\_\_\_ months.

The group agrees to pay Delta Dental of Illinois for *vision* 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.)

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