Delta Dental of Illinois
Application for Group/Employer Policy

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

PROPOSED EFFECTIVE DATE OF GROUP/EMPLOYER POLICY

_____/_____/_____ ☐ New Application ☐ Change	☐ ASO ☐ Fully Insured
☐ Dental ☐ DeltaVision®* ☐ Both	Prior Carrier Information

APPLICANT INFORMATION

Legal Name of Group/Employer _____

Specify the legal name of the group/employer or the Taft-Hartley trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below.

GROUP/EMPLOYER BENEFIT PLAN MAY NOT BE NAMED.

Legal Address	**City**	**State**	**ZIP**
Business Address ***(if different than above)***	**City**	**State**	**ZIP**

Administrator Contact	**Title**	**Administrator Contact Phone** ( )	**Administrator Contact Email**
Billing Contact ***(if different than above)***		**Billing Contact Phone** ( )	**Billing Contact Email** ***(if different than above)***
Eligibility Contact ***(if different than above)***		**Eligibility Contact Phone** ( )	**Eligibility Contact Email** ***(if different than above)***

BROKER/CONSULTANT SECTION

Broker/Consultant Name	**Agency/Firm Name**	
Address	**Phone**	**Email**

General Agent ***(if applicable)***

I certify as the group/employer that all requirements contained in this application have been met.

Name	**Title**
Signature	**Date** _____/_____/_____

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DELTA DENTAL®

Delta Dental of Illinois
Application for Group/Employer Policy

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

The above signed certifies that s/he is authorized to apply for coverage for the selected Group/Employer dental/vision program on behalf of the named Group/Employer and to sign this application, and certifies the application has met all requirements listed below.

In making this application to Delta Dental of Illinois for the selected Group/Employer, Group/Employer 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 Group/Employer represents that all the information contained in the 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 Group/Employer 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 Group/Employer 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.

FOR ASO/SELF INSURED CONTRACTS ONLY: The Group/Employer agrees to fully underwrite the risk of the selected group dental/vision plan and accept liability for payment of benefits.

Application Requirements
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/Employer acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance.

The Group/Employer 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.

Group/Employer 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/employer application form.
- A completed dental and/or vision (as applicable) supplemental questionaire.
- A signed rate quote.
- A deposit for the first month's premium.
- Enrollment. (For those waiving coverage, enrollment forms and supplemental 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.

**DeltaVision is underwritten by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, utilizing the EyeMed Vision Care networks.*

Delta Dental of Illinois Supplemental Questionnaire for Group/Employer Dental Policy

GROUP/EMPLOYER INFORMATION

Group/Employer Name _____

BENEFIT PERIOD

Deductible and Maximum Accumulation:

☐ Contract Year ☐ Calendar Year ☐ Other _____

INITIAL ENROLLMENT

Total Number of Eligibles: _____

Total Number of Eligibles Enrolled: _____

GROUP/EMPLOYER CONTRIBUTION FOR DENTAL

The group/employer contributes:

☐ $_____ or _____% of the cost of the member's insurance.

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

☐ None (Coverage is voluntary)

ELIGIBILITY INFORMATION

PLEASE INDICATE THE ELIGIBILITY REQUIREMENTS FOR ENROLLMENT UNDER THE GROUP/EMPLOYER POLICY.

Enrollment under the group/employer policy will include (select all that apply):

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

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

☐ Domestic Partners for Self funded groups: ☐ Not Offered

Coverage for domestic partners and eligible dependents is a standard benefit for fully insured groups. Coverage for domestic partners and eligible dependents is optional for self funded groups. Self funded groups, please mark "Not Offered" above only if you do not offer this benefit.

Please use the following definition for domestic partners:

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

☐ Retirees: ☐ Retiree age is _____ ☐ Not Offered ☐ Not Applicable (N/A)

Are dependents of retirees covered? ☐ Yes ☐ No ☐ Not Applicable (N/A)

Please use the following definition:

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

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DELTA DENTAL PPO℠/DELTA DENTAL 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 member ceases to be eligible ☐ Last day of the calendar month in which member ceases to be eligible

Dependent children coverage is terminated on:

☐ Birthday ☐ Last day of the calendar month in which the limiting age is reached

Limiting Age

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

Self funded: the limiting age for covered dependent children is _____; and _____ if a full-time student.

DELTACARE® (DHMO)

New Hire Eligibility Date:

On the first month following _____ days of eligibility.

Termination Occurs On:

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

Limiting Age

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

PREMIUM PAYMENTS

Monthly Billing Delivery Information ☐ Email/Online Billing ☐ Paper

Summary Billing includes the summary of enrollees, prior balance, adjustments, current billed and total due by location with a grand total for all locations. If group/employer has multiple locations, does the group/employer require **Summary Billing**? (Fully insured groups/employers only.)

☐ Yes ☐ No

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

Bank Name: _____

Account Number: _____ Routing Number: _____

REMARKS/ADDITIONAL INFORMATION

_____

_____

Please note: Attach your selected plan design with accepted rates/fees when submitting this form.

DELTA DENTAL®

Delta Dental of Illinois Supplemental Questionnaire for Group/Employer DeltaVision® Policy

GROUP/EMPLOYER INFORMATION

Group/Employer Name _____

INITIAL ENROLLMENT

Total number of eligibles: _____ Total number of eligible enrolled: _____

GROUP/EMPLOYER CONTRIBUTION FOR DELTAVISION*

The **group/employer** contributes:

☐ $_____ or _____% of the cost of the member's insurance.

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

☐ None (Coverage is voluntary)

ELIGIBILITY INFORMATION

PLEASE INDICATE ELIGIBILITY REQUIREMENTS FOR ENROLLMENT UNDER THE GROUP/EMPLOYER POLICY. *Enrollment under the group/employer policy will include:*

Is the eligibility the same for DeltaVision as for the Group/Employer Dental Policy? ☐ Yes ☐ No
If no, please specify: _____

New Hire Eligibility Date:

Is the new hire date the same as the Group/Employer Dental Policy? ☐ Yes ☐ No
If no, please specify: _____

Termination Occurs On:

Is the termination date the same as the Group/Employer Dental Policy for members? ☐ Yes ☐ No
If no, please specify: _____
Is the termination date the same as the Group/Employer Dental Policy for dependents? ☐ Yes ☐ No
If no, please specifiy: _____

Limiting Age

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

PREMIUM PAYMENTS

Is the delivery of premium payments the same for DeltaVision as for the Group/Employer Dental Policy? ☐ Yes ☐ No
If no, please specify: _____

REMARKS/ADDITIONAL INFORMATION

_____

Please note: Attach your selected plan design with accepted rates/fees when submitting this form.

**DeltaVision is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.*

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