



Group Application for Pooled or Voluntary PPO Delta Dental of Iowa Coverage

Plan Effective Date: _____
Pooled Groups (2-50 eligible employees)

Pooled Group Rate Structure: 2-tier or 4-tier*
(*4 tier rates for pooled groups available if 10 or more enrolled)

Premier Plans		PPO Plans	
<input type="checkbox"/> Plan A (with Ortho) – Premier	<input type="checkbox"/> Plan A (w/out Ortho) – Premier	<input type="checkbox"/> Plan A (w/Ortho) – PPO	<input type="checkbox"/> Plan A (w/out Ortho) – PPO
<input type="checkbox"/> Plan B (with Ortho) – Premier	<input type="checkbox"/> Plan B (w/out Ortho) – Premier	<input type="checkbox"/> Plan B (w/Ortho) – PPO	<input type="checkbox"/> Plan B (w/out Ortho) – PPO
<input type="checkbox"/> Plan 868 – Premier	<input type="checkbox"/> Plan C – Premier	<input type="checkbox"/> Standard (w/Ortho) – PPO	<input type="checkbox"/> Standard (w/out Ortho) – PPO
<input type="checkbox"/> Standard (w/ Ortho) – Premier	<input type="checkbox"/> Standard (w/out Ortho) - Premier	<input type="checkbox"/> Voluntary PPO Dental Plan (any size group)	

Employer Name _____ Phone (____) _____

Address _____
Street (PO Box) _____ City _____ State _____ Zip _____

Nature of Business _____ Years in Business _____ NAICS (SIC)# _____

Decision Maker Contact _____ Phone (____) _____
Name _____ Title _____

E-Mail Address _____ Fax # _____

Group Billing Contact _____ Phone (____) _____
Name _____ Title _____

E-Mail Address _____ Fax # _____

Billing Invoice Delivery: E-mail notification will be sent to above billing contact when monthly invoice is available to view.

ACH (authorization on 2nd page of group application) monthly check submission

New hires effective 1st of the month following date of hire 30 days 60 days 90 days or other _____

eligible employees _____ # employees enrolling with Delta Dental _____ # with other dental _____ # not enrolling _____

Employer Contribution (N/A - Voluntary PPO): ___% of Single ___% of Family ___% of Employee/Spouse ___% of Employee/Child

Current Medical Carrier _____ Previous Dental Carrier _____

EMPLOYER AGREEMENT

In making this application to Delta Dental of Iowa for group dental coverage, I agree and understand this application will become part of the Contract executed by an authorized officer of Delta Dental of Iowa. It is agreed that the coverage requested is subject to the approval of Delta Dental of Iowa and that no agent or representative has authority to make this application for coverage.

Misrepresentation of submitted information will cause this application and subsequent contract to be null and void.

Signed _____ Title _____

Name _____ Date _____

(Please Print or Type name of person signing application)

AGENT INFORMATION

Agent's Name _____ Phone (____) _____

Agency Name _____ E-mail _____

Agent's Statement: As the acting representative for this group, to the best of my knowledge and ability, I have complied with the underwriting rules as set forth by Delta Dental of Iowa.

Agent's Signature _____ Date _____

For Internal Use Only

Underwriting Information:
Group Number : _____
Category Number: _____
Master Number: _____
Underwriting Initials _____ Date: _____

Marketing Information:
Rep # _____ Brk. ID/Amt. _____
Agent _____ Consultant _____
Participation _____% Contribution _____%
Marketing Initials _____ Date: _____

***GROUP ACCOUNT WITHDRAWAL AUTHORIZATION** (*Premiums are withdrawn on the first working day of each month*)

As an officer having authority to withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa to initiate debit entries to the account at the financial institution indicated below. This authorization is for the purpose of paying Delta Dental for claims and administrative fees, and I understand that the amounts are subject to change based on claim volumes and eligibility changes.

Name of Financial Institution Branch (if applicable)

Address of Financial Institution (Street) City State Zip Code

Bank Routing Number Account Number

This authority is to remain in full force and effect until Delta Dental of Iowa receives written notification, from an officer of this group, of its termination in such time and manner as to allow Delta Dental and the designated financial institution reasonable opportunity to act on it.

I certify to the best of my knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).*

Signature and Title of Officer authorized to withdraw funds Date Signed

*If your banking institution is a foreign bank, please contact Delta Dental of Iowa for further instructions @ 515-261-5515

Pooled Group Enrollment Requirements

Standard Pooled Group Plans Participation and Contribution: (2-50 Eligible Employees):

Participation: A minimum of 50% of your group's total eligible employees must enroll. Or, the total number of enrolled employees must equal 75% of eligible employees excluding those with group dental coverage elsewhere. (A minimum of 2 must enroll)

Contribution: Delta Dental of Iowa recommends the employer contribute 100% of the single rate or 50% of the total premium to insure participation requirements are met.

Voluntary PPO Group Plan Participation:

Participation: Minimum of 2 employees must enroll.

Contribution: Employees pay 100% of premium, the employer administers the plan.

Enrolling a New Group:

1. Complete **all** of the information on the **Application for Pooled or Voluntary PPO Delta Dental of Iowa Coverage**.
2. Enrollment application forms are required for all full-time (or eligible) employees. Those employees wishing to waive coverage must sign the waiver portion of the application form, even though not enrolling. (Not required for Voluntary PPO Dental Plan). Enrollment information can be submitted via Excel spreadsheet, contact Delta Dental of Iowa for the file format if utilizing this option.
3. Provide a copy of the employer's most recent State of Iowa Wage & Tax Report, Form 65-5300. (Not required for Voluntary PPO Dental Plan)
4. You may send a check for the first month's premium, along with this completed group application, and employee enrollment applications to the address shown below or Delta Dental will bill you.
5. All enrollment materials should be sent to us at least 10 working days prior to the effective date of coverage to ensure delivery of information cards and benefit certificates by the effective date.

*Delta Dental of Iowa
Marketing Department
PO Box 9010
Johnston, IA 50131-9010*

*Fax #: 888-264-1433
Toll Free #: 1-877-423-3582*