DELTA DENTAL®

Small Business Dental Application

Email: TeamReNEW@deltadentalia.com
Customer Service: 1-877-423-3582
Fax: 1-888-337-5157

1 EMPLOYER INFORMATION

Company Name _____ Phone (____) _____

Address _____
Street (PO Box) City State Zip County

Industry _____ Years in Business _____ NAICS (SIC)# _____ Tax ID # _____

Decision Maker Contact _____ Phone (____) _____
Name Title

Email Address _____ Fax # _____

Billing Contact _____ Phone (____) _____
Name Title

Email Address _____ Fax # _____

(Email notification will be sent to billing contact named above when monthly invoice is available to view.)

New Hire Effective 1st of the month following: ☐ Date of Hire ☐ 30 Days ☐ 60 Days

Number of Eligible Employees _____ Number of Employees Enrolling with Delta Dental _____

Current Medical Carrier _____ Previous Dental Carrier _____

2 BENEFIT AND RATE INFORMATION

Plan Effective Date: _____

Plan Options

Select **ONE** plan option below. Be sure to select additional details if requested.

☐ **Employer Choice Plan**

If you select an Employer Choice Plan, choose one option from each of the sections below.

Provider Network:
☐ PPO Plus Premier™
☐ Premier®

Plan Choice:
☐ Plan A Prime ☐ Plan C Prime
☐ Plan B Prime ☐ Plan B Plus*

*Plan B Plus includes the Affordable Care Act pediatric Essential Health Benefits.

Corrective Orthodontia:
☐ Yes ☐ No
(Plan B Plus includes medically necessary orthodontia.)

Healthy Smiles Program:
☐ Yes ☐ No
Adding this program will provide eligible employees and their covered spouse with a free electric toothbrush and replacement heads.

Rate Options

If you select an Employer Choice Plan, choose one option from each of the sections below.

☐ Contributory
Rate Structure: ☐ Per Person ☐ 4-Tier
Employer Contributions:
_____% of Employee
_____% of Spouse and/or Dependents **OR**
_____% of Total Premium Contribution **OR**
Total Defined Contribution $ _____
Payroll Deduction Frequency _____
*Any amount of employer contribution is considered to be Contributory.

— OR —

☐ Voluntary
Rate Structure: ☐ Per Person ☐ 4-Tier

OR

☐ **Employee Choice Plans** – Delta Dental PPO Plus Premier™
Employee chooses from available plan options.

3 AGREEMENT AND SIGNATURE

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 contracts to be null and void.

Signed X _____ **Title X** _____

Printed Name X _____ **Date X** _____

4 PAYMENT INFORMATION

Choose one of the following options to pay premiums. Please note, credit card payments will include a surcharge. Debit card payments are not accepted.

☐ **Account Withdrawal:**

Name of Financial Institution _____ Branch *(If applicable)* _____

Address of Financial Institution _____
Street City State Zip

Bank Routing Number _____ Account Number _____

☐ **Credit Card:**

Name as it appears on the card _____

Card number _____

Card type:
☐ VISA ☐ Mastercard
☐ Discover ☐ American Express

Expiration date (MM/YYYY) _____ CVV code (3- or 4-digit code on the front or back of your card) _____

☐ **Check or Online:** *(If you are paying by check or online, you do not need to complete this section.)*

As an officer with authority to charge a credit card or withdraw corporate funds on behalf of _____, I hereby authorize Delta Dental of Iowa and the financial institution named to charge a credit card or withdraw monthly premium payments from the checking or savings account that I selected. I further authorize Delta Dental of Iowa to initiate adjustment entries to this account when necessary.

I understand the first month's premium will be charged to the credit card or withdrawn from the listed account starting on the 1st business day of the month of the policy effective date, and thereafter will be deducted on the 1st business day of each month. This authorization is for the purpose of paying monthly premiums for Delta Dental of Iowa Insurance. This authority to charge the credit card or withdraw payments is to remain in full force and effect until Delta Dental of Iowa has received written notification from an officer of the above named organization of its withdrawal.

I understand in order to revoke my authorization provided or make changes to my payment information, an officer of the above named organization or I must contact Delta Dental of Iowa at TeamService@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010.

Delta Dental of Iowa SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT, ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED, OR YOUR FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

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).

X _____ **X** _____
Signature and Title of Officer Authorized to Pay Premiums Date Signed

5 AGENT INFORMATION

Agent Name _____ NPN Insurance License _____ Phone (_____) _____

Agency Name _____ Email _____

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 **X** _____ **Date** **X** _____

All enrollment materials **should be sent to Delta Dental of Iowa at least 30 days prior to the effective date** of coverage to ensure delivery of identification cards and benefits certificates by the effective date. The following employee enrollment forms must be completed and sent in with your group application:

1. *Employer Choice Plans* – enrollment forms are **required for all eligible employees**. Employees waiving coverage must sign the waiver portion of the form. If enrollment information will be submitted via Excel spreadsheet, please contact Delta Dental of Iowa for the file format.
2. *Employee Choice Plans* – enrollment forms are **only required for employees enrolling in coverage**. Employees waiving coverage do not need to do anything.

Materials should be sent to: TeamReNEW@deltadentalia.com

Delta Dental of Iowa
Team ReNEW
PO BOX 9010
Johnston, IA 50131-9010

DELTA DENTAL®

Required Federal Notice-Nondiscrimination and Accessibility

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa provides free language services to people whose primary language is not English. In addition, Delta Dental provides free services for people with disabilities such as auxiliary aids, written communication in other formats such as large print, audio or other formats. If you need these services, call 1-877-983-3582, hearing impaired (TYY) call 1-888-287-7312.

Language Access Service

If you, or someone you're helping, has questions about Delta Dental of Iowa, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-983-3582.

Arabic –

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Delta Dental of Iowa، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-983-3582.

Chinese – 如果您，或是您正在協助的對象，有關於 Delta Dental of Iowa 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請致電 1-877-983-3582

French – Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Delta Dental of Iowa, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-983-3582.

German – Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Iowa haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-983-3582 an.

Hindi – यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Delta Dental of Iowa के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए 1-877-983-3582 पर कॉल करें।

Karen – နၢ, မ့တမ့ၢ် ပှၤတဂၤဂၤလၢနမၤစၢၤအိၢ,
မ့ၢ်အိဉ်ဒီး တၢ်သံကွၢ်တဖဉ်ဘဉ်ယးဒီးDelta Dental of Iowa နှဉ်,နအိဉ်ဒီး တၢ်ခွဲးတၢ်ယာ်လၢနကဒီးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီး တၢ်ဂ့ၢ်တၢ်ကျိၤလၢ နကျိာ်ဒဉ် နဲလၢ တလိဉ်ဟ့ဉ်ဇဟူးဘဉ်နှဉ်လီၤ. လၢနက
ကတိၤတၢ်ဒီး ပှၤကတိၤကျိာ်ထံတၢ်ဇဂီၢ်, ကိး1-877-983-3582တက့ၢ်.

Korean – 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-983-3582로 전화하십시오.

Laotian – ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-983-3582.

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Delta Dental of Iowa, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-983-3582 uffrufe.

Russian – Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Iowa, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-983-3582.

Serbo-Croatian – Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Delta Dental of Iowa, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-983-3582.

Spanish – Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Iowa, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-983-3582.

Tagalog – Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Delta Dental of Iowa, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-983-3582.

Thai – หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Delta Dental of Iowa คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-983-3582

Vietnamese – Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Iowa, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-983-3582.