DELTA DENTAL®

Large Employer Group Dental Application

1 EMPLOYER INFORMATION

Company Name _____ Phone (____) _____

Address _____
Street (PO Box) City State Zip

Industry _____ Years in Business _____ NAICS (SIC)# _____ FEIN _____

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.)

Eligibility Contact _____ Phone (____) _____
Name Title

Email Address _____ Fax # _____

2 BENEFIT INFORMATION

Plan Effective Date ____/____/____ Renewal Date____/____/____

Please be sure to include signed quote exhibit for requested coverage along with current benefit certificate.
For self-funded plans please include Run-In Administration Form if Delta Dental of Iowa will be processing run-in claims.

Employer Contribution:

____ % of Employee

____ % of Family

____ % of Total Premium Contribution

Number of Eligible Employees: ____

Enrolling with Delta Dental: ____

Benefit accumulation period is: ☐ Calendar Year **OR** ☐ Contract Year

Prior carrier credit to be applied: ☐ Not Applicable ☐ Deductible/Annual Max/Ortho Lifetime Max (if applicable)

3 COBRA

COBRA billed to: ☐ Group ☐ Individual

If bill to individual please provide COBRA rates: ☐ Single ☐ Family ☐ Emp/Spouse ☐ Emp/Child(ren)

Name and email of COBRA administrator: _____

4 BILLING & ADMINISTRATION

New hire eligibility: ☐ 1st of month following ____ days ☐ Date of hire
☐ 1st of month following date of hire ☐ Other: _____

Coverage for Terminated employees/dependents ends: ☐ Last Day of Month **OR** ☐ Last Day Worked

Fully Insured Only:

Payment Method: ☐ Account Withdrawal (complete Payment Information section)
☐ Credit Card (complete Payment Information section)
☐ Check

Self-Funded Only:

Payment Method: ☐ Account Withdrawal (complete Payment Information section)
☐ Credit Card (complete Payment Information section)
☐ Other – please explain _____

Weekly Claims and monthly administration sent via:

☐ Email – please provide contact name/email address _____
contact name/email address _____

☐ Fax – please provide contact name/fax # _____
contact name/fax # _____

(Over, please)

5 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 be 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 X _____ **Title** X _____

Printed Name X _____ **Date** X _____

6 PAYMENT INFORMATION

If you selected Account Withdrawal or Credit Card, please fill out the information below. 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) _____

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.

Self-funded Groups

I understand payments will be charged or withdrawn from the listed account starting on the first Friday following the policy effective date, and thereafter will be charged or deducted once a week on Friday. This authorization is for the purpose of paying claims and administration fees for dental benefits.

Fully Insured Groups

I understand the first month's premium will be charged or withdrawn from the listed account starting on the 1st business day of the month of the policy effective date, and thereafter will be charged or deducted on the 1st business day of each month. This authorization is for the purpose of paying monthly premiums for dental benefits.

This authority to charge a credit card or withdraw premium/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**

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

7 AGENT INFORMATION

Agent Name _____ NPN Insurance License _____

Agency Name _____ Phone (_____) _____

Email _____

Include this group in annual bonus payment program? ☐ Yes ☐ No

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 _____

2793-A10056 06/2022