DELTA DENTAL®

New Group Application & Enrollment Packet

Welcome to Delta Dental of Colorado. We appreciate your business and want to get you on board as efficiently as possible. This packet contains all the forms you will need to fill out and return to us to get set up in our system. Please complete and return all the forms together, including the employee enrollment forms. This helps us ensure that we have all the necessary information for your company to be effective upon your requested date.

If you are completing the forms on your computer, please make sure to do a Save As and add the name of your company to the file name. You can scan your employees' enrollment forms and add them to the PDF to send in if you wish. Or you can print everything out and mail it or fax it. The contact information is included below. If you need help completing these forms or have any questions, please contact your Delta Dental of Colorado sales executive.

REQUIRED FORMS:

- ☐ Original quote
- ☐ Group application form
- ☐ Group Health Plan Certification form
- ☐ ACH Authorization form
- ☐ Website Authorization form
- ☐ Proof of prior coverage (if applicable)
- ☐ Federal wage and tax Schedule C
- ☐ Enrollment forms

Please send the completed and signed small group application packet as detailed above, along with all the subscriber enrollment forms, to:

Delta Dental of Colorado
Sales and Client Services

Email Address:
salesteam@ddpco.com

Mailing Address:
4582 S. Ulster Street, Suite 800
Denver, CO 80237

Fax Number:
303-741-4233

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Group Dental Application

Please complete this application in its entirety. If a section is applicable, all information within that section is required. If a section is not applicable, please mark N/A.

Group Information			
Requested Effective Date: Must be 1st of the month		**FOR DELTA DENTAL USE ONLY.**	
☐ ASC Group (51+ employees) ☐ Risk Group		Group Number:	Sublocations:
Legal Group Name:			
Street Address:			
City, State:	Zip:	Phone:	Fax:

Main Group Contact Information		
Administrative Contact Name:		
Administrative Contact Title:		
Phone:	Fax:	Email Address:

Billing Contact Information (if different from above)			
Billing Entity Name:		Third-Party Administrator? ☐ Yes ☐ No	
Street Address:		City, State:	Zip:
Billing Contact Name:		Billing Contact Title:	
Phone:	Fax:	Email Address:	

North American Industry Classification (NAICS) Code:	Type of Industry:	EIN/TIN:
Method of Payment: ☐ Automatic Clearing House (ACH) ☐ Check		(Groups of less than 10 must choose ACH)

Eligibility & Employer Contribution			
Total number of eligible employees:	Total number of enrolled employees:	Employer contribution toward employee (%):	Employer contribution toward dependents (%):
New Hire Waiting Period (as determined by employer):			
Other employer contribution information:			

Eligibility: All eligible employees (and dependents) who are employed by the group on the inception date of this plan are immediately eligible for coverage. Each present or new employee is an "eligible employee" if he or she 1) works the minimum number of hours required by the employer; 2) is certified as being eligible by the group; 3) received compensation from the group; and 4) is a member of the group as specified in the Group Dental Contract. Note: Dependent eligibility is to age 26, regardless of student status.

Additional Information	
Name of Previous Dental Carrier:	Prior Delta Dental Group Number (if applicable):
Contract Period:	Enrollment Method: Employer Portal (online secure account)

Please see reverse for additional information.

It is agreed that the Group Contract will not become effective unless/until this application is approved and accepted by Delta Dental of Colorado. It is understood that this application will be considered part of the contract between Delta Dental of Colorado and the group listed above.

Authorized Representative Signature: _____

Name: _____ **Date:** _____

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable shall be reported to the Colorado Division of insurance within the Department of Regulatory Agencies.

Agent Information		
Producer Name:	Firm Name:	
Street Address:		
City, State:	Zip Code:	TIN#:
Email:	Phone:	Fax:
Do you currently receive commissions from Delta Dental? ☐ Yes ☐ No	Commission payable to: ☐ Agent ☐ Agency	

Please send the completed and signed small group application packet as detailed on the cover page, along with all the subscriber enrollment forms, to:

Delta Dental of Colorado
Sales and Marketing

Email Address:
salesteam@ddpco.com

Mailing Address:
4582 S. Ulster Street, Suite 800
Denver, CO 80237

Fax Number:
303-741-4233

DELTA DENTAL

Group Health Plan Certification

The _____ Group Health Plan (Plan) does hereby certify to the following:

1. That the Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. That the Plan documents you distribute to employees informing them about their benefits or the Plan documents you are legally required to maintain for your employee benefits plans (such as ERISA Plan documents) have been amended, as required by 45 CFR §164.504(f) and §164.314(b) HIPAA, to incorporate the following provisions and you, as the Plan Sponsor (employer) agreed to:

    a. Not use or further disclose (Protected Health Information (PHI)) other than as permitted by plan documents or as required by law;
    b. Ensure that any agents, including subcontractors, to whom the plan sponsor provides PHI agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;
    c. Not use or disclose PHI for employment-related actions and decisions;
    d. Report any inconsistent use or disclosure of PHI to the group health plan;
    e. Make PHI available to an individual based on HIPAA's access requirements;
    f. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
    g. Make available the information required to provide an accounting of disclosures;
    h. Make internal practices, books and records relating to the use and disclosure of PHI received from the Group Health Plan available to the Secretary of Health and Human Services to determine the Plan's compliance with HIPAA;
    i. Ensure that adequate separation between the Group Health Plan and the Plan Sponsor is established as required by HIPAA (45 CFR §164.504(f)(2)(iii)) and that such separation is supported by reasonable and appropriate security measures;
    j. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible;
    k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan;
    l. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    m. Report to the group health plan any security incident of which it becomes aware.

1. The undersigned further certifies that he or she has the authority to sign on behalf of the Plan.

Printed Name of Plan Representative: _____

Signature of Plan Representative: _____

Delta Dental Group Number: _____ **Date:** _____

Delta Dental of Colorado puts a high priority on compliance with laws and regulations under which it operates and is dedicated to protecting the information of our enrollees.

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Automatic Draft Authorization Form
For employer groups

Please complete the form and return it to the address listed below.

☐ New authorization

☐ Changes to existing authorization (changes will be completed within 10 days of receipt of this form)

Group Information	
Group Name:	Group Number:
Contact Name:	Phone:
Fax:	Email:

I (we) hereby authorize Delta Dental of Colorado, hereinafter called "Company," to initiate debit entries from our account indicated below and the bank named below. I understand that employer groups eligibility can be placed on hold for a rejected draft. I also understand that this specified account would be deducted no later than 48 hours after a claims premium invoice is sent to the group contact.

Account Information	
Account Type: ☐ Checking ☐ Savings	Financial Institution:
	Branch:
Transit ABA Number (Routing Number):	
Account Number:	

This authority is to remain in full force and effect until Company has received notification from us of termination in such a time and such a manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized Representative Signature: _____

Name: _____ **Date:** _____

Self-Funded Groups Only
Please automatically draft: ☐ Administrative fees only ☐ Administrative fees + claims payment

Please return this completed form as part of the new group application and enrollment packet to salesteam@ddpco.com. See the cover sheet for all the required forms.

DELTA DENTAL

Website Authorization Form

Purpose: This form allows a Plan Sponsor to open website accounts for authorized individuals and business associates for purposes of submitting enrollment information and obtaining access to group activity reports, eligibility reports, and bills. Access to certain reports may be contingent upon the type of protected health information (PHI) disclosed and whether the group is experience-rated. Please note that contract arrangements in which Delta Dental of Colorado (DDCO) assumes financial risk are referred to as experience-rated groups; whereas groups in which DDCO only provides administrative services are referred to as self-funded group.

Plan Sponsor Requesting Authorization	
Group Name:	Group Number:
Address:	
Telephone:	Email Address:

Fill out one form for each employee requiring access. Provide employee name, email, and phone number for the individual and identify the access authorized for that individual by checking the box next to the service. Please also supply a keyword in the event a password is forgotten (applicable only for those requiring a password).

☐ Add User ☐ Terminate User

Full Name:		
Telephone:	Email Address:	
Keyword (choose one): Last 4 digits of SSN:	Pet Name:	Mother's Maiden Name:

The group, acting through its undersigned representative, certifies that the individual identified above is authorized to access the checked options below and perform the functions associated with each option on the group's behalf and hearby authorizes DDCO to open a website account for the individual set forth above.

Enrollment	**View Invoices**	**Enrollment Access to Pay Bills**
☐ Full Access (adds, changes, terms)	☐ Yes	☐ Yes (incl. remittance page or ACH info.)
☐ View Only (for electronic filers)	☐ No	☐ No

☐ Receive electronic error (EE) reports
☐ Allow broker/consultant access to management reports
☐ Management Reports: Current reports available include summary level data about the performance of your dental plan, such as number of claims paid, premiums paid, enrollment by month, network utilization and cost containment savings.
☐ View Eligibility Recap Report (self-funded groups only): The Eligibility Recap Report provides a monthly recap of subscribers and dependents who are eligible for insurance under the group dental plan.
☐ View Group Activity Reports Level One (self-funded groups only): Provides a monthly summary of claims history that includes detailed subscriber level information.
☐ View Group Activity Reports Level Two (self-funded groups only): Provides a monthly summary of claims history without subscriber information.

AUTHORIZATION AND CONDITIONS FOR PRIVILEGES GRANTED.

In consideration for the privileges set forth in this Website Authorization form, the group, acting through it, hereby agrees to the following conditions:

1. DDCO may rely on electronically submitted enrollment data to the same extent as if submitted by non-electronic means;
2. Group will undertake reasonable measures to safeguard account information, including user name and password, and to prevent unauthorized access to the website by someone acting or purporting to act on the group's behalf;
3. All authorization requests (adds, changes, terms) need to be submitted via email to group_admin@ddpco.com or faxed to 303-741-9160;
4. Group shall be solely responsible for any liability arising from the use of the website account and shall indemnify, hold harmless, and defend DDCO against any claim arising from the authorized user's use of the website account or the group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws; and
5. The individual signing this application form has the authority to permit the requested access and bind the group to the terms and conditions set forth above.

Authorized Representative Signature: _____

Name: _____ **Date:** _____

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Enrollment Form

Applicant: Select an insurance plan or Patient Direct discount plan (below).

❑ Delta Dental Premier®
❑ Delta Dental PPO℠
❑ Delta Dental PPO℠ Plus Premier
❑ Exclusive Panel Option (EPO)
❑ Delta Dental MAC PPO℠

❑ Delta Dental Patient Direct® (for Patient Direct, the following fields are mandatory):

1. Patient Direct Provider Name: _____

2. Patient Direct Provider Number: _____

❑ New Enrollment ❑ Waive Coverage ❑ Change Coverage | ❑ Active ❑ Retired ❑ COBRA/State Continuation

Employee Information (please print clearly or type). All fields are required.

Employer:		Group #:	Subgroup #:
SSN:	Date of Birth:	Date of Hire:	Effective Date:
Last Name:		First Name:	❑ M / ❑ F
Street Address:		City:	State: Zip:
Email Address:			Cell Phone:

Would you like to receive communications from Delta Dental of Colorado by email and text message? ❑ Yes ❑ No
Your email address and cell phone will not be used for any purpose other than communications from Delta Dental of Colorado.

Select Coverage: ❑ Employee Only ❑ Employee and Spouse ❑ Employee and Children ❑ Employee, Spouse, and Children

Please list all dependents. All fields are required.

Add	Delete	Last Name	First Name	SSN	Date of Birth	M	F
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑

If you need more space to list additional dependents, please use a second enrollment form.

Changes to Existing Eligibility

Date change is effective (mm/dd/yyyy):

Reason for change/explanation:	List effective date for checked boxes below.	
❑ Name Change (list above)	❑ Marriage	Date: _____
❑ Cancel Coverage	❑ Birth/Adoption*	Date: _____
❑ Employment Terminated	❑ Divorce	Date: _____
❑ Reinstatement of Coverage (see reverse)	❑ Death	Date: _____
❑ Address Change (list above)	❑ No Longer Eligible	Date: _____
❑ COBRA/State Continuation (list start date above)	❑ Part-time to Full-time	Date: _____
❑ Late Enrollment (if applicable)	❑ Retiree	Date: _____
❑ Family Status Change	❑ Add Disabled Child*	Date: _____
❑ Add Dependent ❑ Delete Dependent	❑ Transfer to Group/Subgroup: _____	Date: _____
❑ Other Reason for Change: _____		

I understand that the terms of the contract between Delta Dental and my company may not allow for late enrollment for my dependents. The contract may allow for late enrollments but may require waiting periods or additional limitations.

Employee's Signature **Date**

It is unlawful to knowingly provide false, incomplete, or misleading information to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217-5468

Phone: 303-741-9300, ext. 3900
Toll-free: 1-800-233-0860, ext. 3900

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department representative can help you.

Status Definitions
Status definitions appear near the top of the enrollment form. Please check the appropriate box in each section.

New Enrollment: Check for first-time enrollment for you or your dependents.

Waive Coverage: Check if you do not want to take dental coverage. Please note that not all plans allow waiving of coverage.

Change Coverage: If you are making changes to your existing enrollment information, please check this box and complete the appropriate information under Changes to Existing Eligibility near the bottom of the form.

Also complete the following:

Active: You are a current employee.

Retired: You are retired, and your group continues to provide you with dental benefits.

COBRA: You are no longer an active employee, but you have continued self-paid coverage under COBRA.

Group Number/Subgroup Number
Please enter the Delta Dental group number for the program you are enrolling in. If your employer uses subgroup numbers, please include the appropriate subgroup number. If you are unsure of your group and/or subgroup number, please contact your human resources department.

Employee Information
This section must be completed to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date
The date that Delta Dental coverage takes effect for you and/or your dependents.

List of Dependents
This section should be completed when:
1.) Enrolling dependents and/or
2.) You have checked Change Coverage and are changing information that was previously submitted to Delta Dental. Please include both first and last names, date of birth, and Social Security numbers for any individuals for whom you are enrolling or submitting a change or correction.

Standard Dependent Definitions (May Vary)

Spouse: Your legal spouse.

Child(ren): Includes unmarried and married child(ren), step-child(ren), legally adopted child(ren), and court-ordered foster child(ren) in a parent/child relationship who meet the age limits specified between your employer and Delta Dental.

Common Law: If you add a common-law spouse and later cancel coverage for this individual, you will be required to provide legal documentation before another common-law can be added to the plan. List Common Law as spouse.

Civil Union: Civil Union is included in all fully insured employer group contracts with Delta Dental. Fully insured groups offer this as a dependent option; therefore, please list partner as a spouse and provide all information requested.

Domestic Partner: May not be included in all employer group contracts with Delta Dental. If your group offers this as a dependent option, please list partner as a spouse and provide all information requested.

Disabled or Full-time Student: If you have a disabled child or a full-time college student, please provide supporting documentation.

Changes to Existing Eligibility Information
This section should be completed only if you are making changes to your existing enrollment information.

Reinstatement: Check for reinstatement coverage for yourself or your dependents. Please provide reason for reinstatement (divorce, loss of coverage, etc.) under Other Reason for Change.

Cancel Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member. This is not the same as Employment Termination.

Group Transfers: When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, please include an effective date of change and clearly state the reason for the change. Please attach supporting documentation to the enrollment form and submit to your HR office.

Privacy Policy Statement
It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof who knowingly provides false, incomplete, or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits to the Colorado Division of Insurance.

Enrollment forms, changes, and those items requiring supporting documentation should be submitted to your human resources department office so they can make changes to your plan through Delta Dental of Colorado's employer portal.

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217-5468

Phone: 303-741-9300, ext. 3900