DELTA DENTAL®

Fully Insured New Group Application and 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 (*Send eligibility as an Excel spreadsheet attachment. Please do not submit in PDF format.*) Or you can print everything out and mail 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

- ☐ Fully Insured new group application form
- ☐ Product and benefit options
- ☐ ACH authorization form
- ☐ Employer portal authorization form
- ☐ Group health plan certification
- ☐ Employee enrollment forms

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

Delta Dental of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL®

Fully Insured
New Group Dental Application

Please complete this application in its entirety. For quicker and more accurate processing, please save this form to your computer, rename the file, and type your responses.

Group Information

Requested Effective Date: Must be 1st of the month	**For Delta Dental use only** Group #: Sublocations (divisions):
Legal Group Name:	EIN/TIN:
Street Address:	
City, State: Zip:	Phone: Fax:

Group Contact's Information

Contact Name:	Contact Title:
Phone: Fax:	Email Address:

Other Contact Information

(Only complete this section if billing information is different than above.)

Billing Entity Name:	Third Party Administrator (TPA) ☐ Yes ☐ No
Address:	City, State: Zip:
Contact Name:	Contact Title:
Phone: Fax:	Email Address:

Product Selection

Plan 1: Single Option: (*Select a Product*)

- ☐ Delta Dental PPO plus Premier™
- ☐ PPO Reimbursement / Maximum Allowable Charge (MAC)
- ☐ Delta Dental PPO™
- ☐ Delta Dental Patient Direct®
- ☐ Delta Dental Premier®

Plan 2: Dual Option Products

- ☐ Delta Dental PPO plus Premier
- ☐ PPO Reimbursement Maximum Allowable Charge (MAC)
- ☐ Delta Dental PPO
- ☐ Delta Dental Patient Direct
- ☐ Delta Dental Premier

Other | Vision

- ☐ Delta Dental Patient Direct
- ☐ DeltaVision® 150 Plan
- ☐ DeltaVision 175 Plan
- ☐ DeltaVision 175 Plan+ EasyOptions plan
- ☐ Other (please type description)

Employee Participation and Employer Contribution

Total number of eligible employees:	Total number of enrolled employees:	Employer contribution toward employee (%):	Employer contribution toward dependents (%):

Other employer contribution information:

Employee Eligibility

Dependents covered to age 26? ☐ Yes ☐ No	If no, indicate dependent age:

New hire waiting period: Amount of time employees must wait before eligible for benefits.

- ☐ 1st of the month following 3 months
- ☐ As determined by employer*
- ☐ Exact date of hire
- ☐ 1st of the month following _____ days
- ☐ 1st of the month following _____ months

Same-sex domestic partner coverage? ☐ Yes ☐ No

Civil Union coverage? ☐ Yes ☐ No

Are there classes of employees with different eligibility periods?	*If yes, select first eligibility class:	Select second eligibility class:	Indicate the eligibility waiting period for second class of employees:
☐ Yes ☐ No	☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Hourly/Non exempt ☐ Salary/Exempt ☐ Management ☐ Executive ☐ All others	☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Hourly/Non exempt ☐ Salary/Exempt ☐ Management ☐ Executive ☐ All others	

Rates

☐ **Check this box if group is net of commission**

All rates listed are per month

Plan 1 | Single Option

Tier 4	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Tier 3	Employee Only	Employee + 1	Employee + 2 or More	
Tier 2	Employee Only	Employee + Family		
	Composite			

Plan 2 | Dual Option

Tier 4	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Tier 3	Employee Only	Employee + 1	Employee + 2 or More	
Tier 2	Employee Only	Employee + Family		
	Composite			

Other | DeltaVision®

Tier 4	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Tier 3	Employee Only	Employee + 1	Employee + 2 or More	
Tier 2	Employee Only	Employee + Family		
	Composite			

General Information

Name of previous dental carrier:		Prior Delta Dental group number (if applicable):	
NAICS (industry code):	Is a Schedule A required? ☐ Yes ☐ No	Web reporting? ☐ Yes* ☐ No	* If yes, requires additional information for security purposes.

Enrollment, Payment, and Billing

Initial enrollment method - Choose one	Payment method: Groups with less than 10 enrolled employees must select ACH	Ongoing enrollment method:
☐ DDCO Spreadsheet ☐ EE/EDI ☐ Web Tool ☐ Paper	☐ ACH ☐ Check ☐ Wire	☐ EE/EDI ☐ Web Tool

Contract Information and Signatures

Group Effective Date:	Contract Period: ☐ 12 Months ☐ 24 Months ☐ 36 Months ☐ Other - (Please explain in box)	If you selected "Other" for contract period, please provide more information.
Benefit Period for Deductible/Maximum: ☐ Calendar year (Small Group Standard) ☐ Contract year	Estimated First Month's Premium:	

***For Delta Dental Use Only**

Delta Dental Sales Executive:
Delta Dental Account Manager:

Signature of Authorized Group Representative **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.

Producer Information

Producer Name:	Firm Name:	
Street Address:		
City, State:	ZIP Code:	TIN/SSN:
Email:	Phone:	Fax:
Do you currently receive commissions from Delta Dental? ☐ Yes ☐ No	Web reporting*? ☐ Yes ☐ No	

General Agency Information (if applicable)

General Agency Name:	Contact:	
Street Address:		
City, State:	ZIP Code:	TIN/SSN:
Email:	Phone:	Fax:
Cannot contract with Delta Dental of Colorado? ☐ Yes ☐ No	Web reporting*? ☐ Yes ☐ No	* If yes, requires additional information for security purposes.

Please send completed and signed Self-Funded Group Dental Application, original quote, ACH or Wire Authorization form, Employer Portal Authorization form, HIPAA certificate for Fully Insured groups or BAA for Self-Funded groups, and employee enrollment forms (if applicable) to:

Delta Dental of Colorado
Sales and Client Services
salesteam@ddpco.com

6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

DELTA DENTAL®

Product and Benefit Options

Attach: Solo plan quote(s) with rate sheet(s) for all options.

☐ Delta Dental Large Group (100+ enrolled employees)

-Please include original quote with New Group Dental Application

☐ Delta Dental Small Group (10-99 enrolled employees)*

Select a Plan:

- ☐ Plan 1 - MAC PPO™
- ☐ Plan 2 - MAC PPO
- ☐ Plan 2A - PPO plus Premier™
- ☐ Plan 3 - PPO plus Premier
- ☐ Plan 4 - PPO plus Premier
- ☐ Plan 5 - PPO plus Premier
- ☐ Plan 6 - PPO plus Premier
- ☐ Plan 7 - MAC PPO
- ☐ Custom Plan

Periodontics/Endodontics/Oral Surgery:

- ☐ Covered in Basic Services
- ☐ Covered in Major Services

Prevention First, Right Start 4 Kids®, Posterior Composites, and Implants:

- ☐ Covered (Classic)
- ☐ Not Covered (Lite)

-Dual Choice plans are available only for groups of 25+ enrolled employees

Orthodontics Included?

- ☐ Yes
- ☐ No

☐ Patient Freedom (2-49 enrolled employees)*

Select a Group Size Segment:

- ☐ 2-9 enrolled employees
- ☐ 10-49 enrolled employees

Select a Plan:

- ☐ Plan 1 Enhanced
- ☐ Plan 2 Enhanced
- ☐ Plan 3 Enhanced
- ☐ Plan 4 Enhanced
- ☐ Plan 1 Standard
- ☐ Plan 2 Standard
- ☐ Plan 3 Standard
- ☐ Plan 4 Standard

Orthodontics Included?

- ☐ Yes
- ☐ No

-Groups of 10 or more enrolled employees
-$1,000 lifetime maximum
-50% coverage to age 19 for covered dependents

☐ Beta Health*

Select a Plan:

- ☐ Plan 1
- ☐ Plan 2
- ☐ Plan 3
- ☐ Plan 4

Orthodontics Included?

- ☐ Yes
- ☐ No

- Groups of 10 or more enrolled employees
- $1,000 lifetime maximum
- 50% coverage to age 19 for covered dependents

DELTA DENTAL®

Product and Benefit Options

☐ Delta Dental/Kaiser Permanente Small Group Dental Plans*

Select a Plan:

- ☐ 11671 (Formerly 1851) – Standard Option
- ☐ 11671 (Formerly 1851) – Standard plus Ortho Option
- ☐ Adult Only Comprehensive Option 1
- ☐ Adult Only Comprehensive Option 2

☐ Delta Dental/COPIC/CMS Dental Program

Select a Plan:

- ☐ High Option
- ☐ Low Option
- ☐ Delta Dental PPO plus Premier (Includes Child-Only Orthodontia)
- ☐ Delta Dental PPO

☐ Delta Dental Patient Direct® Savings Plan

☐ DeltaVision®

Select a Plan:

- ☐ DeltaVision 150 Plan
- ☐ DeltaVision 175 Plan
- ☐ DeltaVision 175 + Plan EasyOptions Plan

Additional Comments:

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 of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL

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 ☐ Claims 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 of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL

Employer Portal Authorization Form

This form allows a plan sponsor to open an account on the secure employer portal for authorized individuals and business associates for purposes of submitting enrollment information and obtaining access to group activity reports, and 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.

Plan Sponsor Requesting Authorization
Group Name:
Group Number: *If specific sub and sub-sub account access is needed, please specify the numbers. If only the top account number is provided, access to all sub and sub-sub accounts will be granted

Fill out one form for each employee requiring access. Provide user name, email, and phone number for the individual and identify the access authorized for that individual by checking the box next to the service.

☐ Add User ☐ Terminate User

Full Name:	Telephone:
Email:	

The group, acting through its undersigned representative, certifies that the individual identified above is authorized to access the web roles listed below and perform the functions associated with each option on the group's behalf and hereby authorizes DDCO to open a portal account for the individual set forth above (access requires password).

Only one box should be selected from each of the three sections below

Role	View/Modify	Account Type
☐ Eligibility and Reporting (not available for Small Group Pool)	☐ View	☐ Fully Insured
☐ Eligibility, Bills, and Reporting (not available for Small Group Pool)	☐ Modify	☐ Self-Funded
☐ Reports Only (not available for Small Group Pool)	(Modify access is not available for electronically filed groups. If modify access is needed for members not submitted on the file, select modify above, but note that electronically filed members will still default to view only)	☐ Small Group Pool (Patient Freedom, BETA, Kaiser Small Group, Small Group Direct & COPIC)
☐ Eligibility and Bills (only available for Small Group Pool)		
☐ Eligibility Only (only available for Small Group Pool)		
Employee Statuses and Departments*: *Please specify any specific employee statuses (active, COBRA, LOA, etc) that you need access to manage/view, as well as any group specific departments. If access to all employees and all departments are needed, this field can be left empty.		

Reports include:

- **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.
- **Eligibility Error Report** The Eligibility Error Report provides detail and descriptions of enrollment errors that need to be corrected on the eligibility file. (only for electronically filed groups)
- **Eligibility Recap Report (self-funded groups only):** The Eligibility Recap Report provides a monthly recap of subscribers and dependents that are eligible for insurance under the group dental plan.
- **Group Activity Reports (self-funded groups only):** Provides a monthly summary of claims history that includes detailed subscriber level information.

☐ **Claims-Level Access to Facilitate Client-Managed Customer Service (self-funded groups only):** Provides individual member benefits and claims information to employee or other designee of self-funded group for use in group-administered customer service functions.

continued on next page

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 requests (adds, changes, terms) need to be submitted via email to **salesteam@ddpco.com**. DDCO shall have three business days (excluding holidays) to process such requests;
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:**

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 of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL

Group Health Plan Certification (HIPAA)

DeltaVision® and Delta Dental Patient Direct® only

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

Name of Employer Group

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.

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 of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL®

Employee Enrollment Form

IMPORTANT: Enrollment forms with incomplete or missing information will be returned.

This Section to Be Completed By the Group Administrator

Account Name:		Effective Date:
Account No:	Sub-Account No:	Sub-Sub Account No:
Department:		Benefit Plan (Ex: Low or High):

Employment Status (choose one):
❑ Active ❑ COBRA ❑ Continuation ❑ Disability/LTD
❑ Leave of Absence ❑ Retiree ❑ Retiree-Early ❑ Surviving Dependent

Employee Type (choose one):
❑ Hourly ❑ Salaried ❑ Full-Time ❑ Part-Time
❑ Temporary ❑ Reduced Schedule ❑ Salaried Non-Exempt

Section A: Enrollment/Change

❑ New Hire ❑ Open Enrollment ❑ Reinstatement ❑ Cancel Coverage ❑ COBRA (Effective Date _____/_____/_____/)

Qualifying Event: ❑ Add dependent, spouse, or domestic partner ❑ Drop dependent, spouse, or domestic partner
Reason(s) For Qualifying Event: ❑ Marriage ❑ Loss of other group coverage ❑ Divorce ❑ No longer a dependent ❑ Birth or adoption
❑ Death of spouse/dependent ❑ Other_____

❑ Previous Name_____ ❑ Address ❑ Telephone ❑ Other_____

❑ Decline Coverage - **I understand that I have been offered and have elected to decline coverage under my employer sponsored dental plan with Delta Dental at this time. I will not be eligible to enroll until the next open enrollment period or in the event of a qualifying event.**

(Sign, date, and complete the first line of section B.) Signature:_____ Date:_____

Section B: Employee Information

Last Name:	First Name:	MI:	Social Security Number: _____-_____-_____
Mailing Address:	City:	State:	Zip:
Home Telephone:	Date of Birth: _____/_____/_____	Gender: ❑ Male ❑ Female ❑ Unspecified	
Marital Status: ❑ Single ❑ Married	Date of Hire: _____/_____/_____	Group Assigned ID (if applicable):_____	
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.

Section C: Coverage

Dental (check one): ❑ Delta Dental Premier® ❑ Delta Dental PPO™
❑ Delta Dental PPO plus Premier™ ❑ Exclusive Panel Option (EPO)
❑ Delta Dental MAC PPO™ ❑ Delta Dental PPO™ Reimbursement
❑ Delta Dental Patient Direct® (complete required section below)

DeltaVision® (check one, if applicable):
❑ DeltaVision 150 Plan
❑ DeltaVision 175 Plan
❑ DeltaVision 175 + EasyOptions Plan

Patient Direct Provider Name:

Provider Practice Name: Office ID:

Coverage Type | Dental (check one):
❑ Employee ❑ Employee + Child ❑ Employee + Children ❑ Employee + Spouse (Domestic Partner/Common Law/Civil Union)
❑ Employee + Family

Coverage Type | Vision (check one):
❑ Employee ❑ Employee + Child ❑ Employee + Children ❑ Employee + Spouse (Domestic Partner/Common Law/Civil Union)
❑ Employee + Family

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 of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

Section D: List All Members to Be Enrolled/Dropped Based on the Coverage Type Selected:
Dental Coverage

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F/U)	Date of Birth (MM/DD/YYYY)
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						

Section D: List All Members to Be Enrolled/Dropped Based on the Coverage Type Selected:
DeltaVision® Coverage

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F/U)	Date of Birth (MM/DD/YYYY)
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						

Section D: List All Members to Be Enrolled/Dropped Based on the Coverage Type Selected:
Delta Dental Patient Direct® Coverage

	Last Name (if different)	First Name, MI	SSN	Relationship	Gender (M/F/U)	Date of Birth (MM/DD/YYYY)
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						
❑ Add ❑ Drop						

Section E: Authorization and Certification

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.

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.