DELTA DENTAL®

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)
Does group allow for domestic partner coverage? ☐ Yes ☐ No	

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:
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111

Fax Number:
303-741-4233