DELTA DENTAL®

Self-Funded 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 (*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

- ☐ Original quote (please include plan and rate information)
- ☐ Self-Funded new group application form
- ☐ Product and benefit options
- ☐ ACH authorization form
- ☐ Employer portal authorization form
- ☐ Proof of prior coverage (if applicable)
- ☐ Federal wage and tax Schedule C enrollment forms (may be required)
- ☐ Employee enrollment forms
- ☐ Abbreviated application for existing group | add DeltaVision®, Delta Dental Patient Direct®, change plan options
- ☐ Group Business Associate Agreement

Please send the completed and signed Self-Funded New Group 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®

Self-Funded 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 Premier®
- ☐ Other, (please describe in box)

Plan 2: Dual Option Products

- ☐ Delta Dental PPO Plus Premier
- ☐ PPO Reimbursement Maximum Allowable Charge (MAC)
- ☐ Delta Dental PPO
- ☐ Delta Dental Premier
- ☐ Other, (please describe in box)

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

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

Dependents covered to age 26? ☐ Yes ☐ No If no, indicate dependent age:	Same-sex domestic partner coverage? ☐ Yes ☐ No	Civil Union coverage? ☐ Yes ☐ No

Rates

Check this box if group is net of commission ☐

Admin Fee ($):

Fees listed are per employee, per month

Plan 1 | Single Option
Equivalent Rates

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		

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		

Other | DeltaVision®
Fully Insured

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		

General Information

Name of previous dental carrier:		Prior Delta Dental group number (if applicable):	
NAICS (industry code):	Is a schedule C 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	Claims: ☐ ACH ☐ Wire	Admin Fee: ☐ ACH ☐ Wire ☐ Check	☐ 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		

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.

***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:	Agency 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	* If yes, requires additional information for security purposes.

General Agency Information (if applicable)		
General Agency Name:	Contact:	
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	* If yes, requires additional information for security purposes.

Please send completed and signed Fully Insured 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
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL

Product and Benefit Options

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

☐ Self-Funded Dental Plan

* Please include original quote with New Group Dental Application

☐ 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.

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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

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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.

***Additional forms required for each authorized individual.**

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 ☐ Modify (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)	☐ Fully Insured ☐ Self-Funded ☐ Small Group Pool (Kaiser Small Group, Small Group Direct & COPIC)
☐ Eligibility, Bills, and Reporting (not available for Small Group Pool)		
☐ Reports Only (not available for Small Group Pool)		
☐ 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:**

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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

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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						

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

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.

DELTA DENTAL®

Application to add DeltaVision® and/or Delta Dental Patient Direct® to Existing Group

Group Information			
Requested Effective Date: Must be 1st of the month		Group #:	
☐ Fully Insured		Sublocations (divisions):	For Delta Dental use only.
Legal Group Name:		EIN/TIN:	
Street Address:			
City, State:	ZIP code:	Phone:	Fax:

Group Contact's Information		
Contact Name:		Contact Title:
Phone:	Fax:	Email Address:

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	

Product Selection	
Single Option: (*Select a Product*)	Dual Option: (*Select a Product*)
Delta Dental PPO Plus Premier™	Delta Dental PPO Plus Premier
PPO Reimbursement / Maximum Allowable Charge (MAC)	PPO Reimbursement / Maximum Allowable Charge (MAC)
Delta Dental PPO™	Delta Dental PPO
Delta Dental Patient Direct®	Delta Dental Patient Direct
Exclusive Panel Option (EPO)	Exclusive Panel Option (EPO)
Delta Dental Premier®	Delta Dental Premier
DeltaVision® 150 Plan	DeltaVision 150 Plan
DeltaVision 175 Plan	DeltaVision 175 Plan
DeltaVision 175+EasyOptions Plan	DeltaVision 175+EasyOptions Plan
Other, (If other, please describe)	Other, (If other, please describe)

DELTA DENTAL®

Rates				
☐ Check this box if group is net of commission				
All rates listed are per month				
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 Rate			

If more than one dental plan option, please add additional rates and notes here:

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.

*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.

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Delta Dental of Colorado
Group Business Associate Agreement

The Business Associate Agreement ("Agreement") dated _____, 2025 (the "Effective Date"), is entered into by and between _____ ("Covered Entity"), and Delta Dental of Colorado ("DDCO") ("Business Associate").

I. Applicability; Conflicts

This Agreement applies with respect to all contracts or other arrangements by and between Covered Entity and Business Associate that involve the use or disclosure of Protected Health Information (PHI).This Agreement addresses the Business Associate requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the American Recovery and Reinvestment Act of2009 ("ARRA")/HITECH Act (P.L. 111-005), HIPAA's implementing regulations (45 C.F.R. Parts 160 and 164),as well as Colorado's statutes related to consumer protection through data privacy (C.R.S. §§ 6-1-713,713.5, and 716), all as may be further amended from time to time. Capitalized terms used but nototherwise defined in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160, 162and 164, as amended from time to time. As used in this Agreement, all references to PHI shall refer tothe PHI of Covered Entity unless stated otherwise. Any ambiguity in this Agreement shall be resolved infavor of a meaning that permits Covered Entity to comply with HIPAA.

II. Definitions

a. Catch-all definition. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information(PHI), Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

b. Specific definitions

i. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 C.F.R. § 160.103.

ii. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity"at 45 C.F.R. § 160.103, except that it shall be expanded to include any person or entity that maintains,owns, or licenses Personal Identifying Information in the course of the person's business, vocation, oroccupation.

iii. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and EnforcementRules at 45 C.F.R. Part 160, 162, and 164 and the HITECH Act.

iv. Personal Identifying Information (PII). "Personal Identifying Information" shall have the same definition as in C.R.S. § 6-1-713(2)(b).

III. Obligations and Activities of Business Associate

Business Associate agrees to:

a. Not use or disclose PHI other than as permitted or required by the Agreement or as required by law;

b. Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information (ePHI), to prevent use or disclosure of PHI other than as provided for by the Agreement;

c. Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement;

d. Comply with the security requirements referenced in Section 13401 of ARRA, including the requirements of 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316;

e. Understand that it is now subject to the same federal penalties (ARRA Section 13401(b)) as Covered Entity for violation of the security requirements referenced therein. Business Associate accepts full responsibility for any penalties incurred as a result of its own breaches or violations of Covered Entity's PHI;

f. Report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 C.F.R.§ 164.410, and any security incident of which it becomes aware;

g. Following the discovery of any use or disclosure of "unsecured PHI" as defined in 45 C.F.R. § 164.402 notify Covered Entity of such use or disclosure within ten (10) business days. The notice shall include (i) the identification of each individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed, (ii) identify the nature of the breach, including the date of discovery and the date of the breach, (iii) identify the types of PHI used or disclosed, (iv) describe what Business Associate is doing to investigate the breach, mitigate harm and protect against further breaches. A breach is discovered as of the first day on which such breach is known to Business Associate or should have been reasonably known to Business Associate;

h. Once discovery of a breach of unsecured PHI by Business Associate has been reported to Covered Entity, Covered Entity will provide notification to the Individual, the HHS Office for Civil Rights (OCR) and potentially the media, unless other arrangements have been made with Business Associate;

i. Use and disclose PHI only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 C.F.R. § 164.504(e) (Uses and disclosure: Organizational requirements: Business Associate contracts) and the privacy requirements referenced in Section 13404 of ARRA;

j. Comply with any and all privacy and security regulations issued pursuant to ARRA/HITECH Act and applicable to Business Associate as and when those regulations are effective;

k. In accordance with 45 C.F.R.§§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

l. Make available, at the request of Covered Entity, within fifteen (15) days, PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity to an Individual as necessary to satisfy Covered Entity's obligations under 45 C.F.R.§ 164.524;

m. Make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by the Covered Entity pursuant to 45 C.F.R.§164.526, at the request of Covered Entity or an Individual, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R.§ 164.526, and to do so within twenty (20) days;

n. Maintain and make available the information required to provide an accounting of disclosures for the Covered Entity to respond to a request by an Individual or to an Individual for an accounting of disclosures of PHI as necessary to satisfy Covered Entity's obligations under 45 C.F.R.§ 164.528; and to do so within twenty (20) days;

o. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s); and

p. Make its internal practices, books, and records available to the Secretary and to the Covered Entity for purposes of determining compliance with the HIPAA Rules.

IV. Permitted Uses and Disclosures by Business Associate

a. Except as otherwise limited in this Agreement, Business Associate may only use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Entity, pursuant to the Agreement between Covered Entity and Business Associate, provided that such use or disclosure would not violate HIPAA if done by Covered Entity;

b. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R.§ 164.502(j)(1);

c. Business Associate may use or disclose PHI as required by law;

d. Business Associate agrees to make uses and disclosures and requests for PHI consistent with Covered Entity's minimum necessary policies and procedures;

e. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except for the specific uses and disclosures set forth below:

i. Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate;

ii. Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

iii. Business Associate may provide data aggregation services relating to the health care operations of the Covered Entity.

V. Provisions for Covered Entity to Inform Business Associate of Limitations and Restrictions

a. Covered Entity shall notify Business Associate of any limitation(s) in the Notice of Privacy Practices of Covered Entity under 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI;

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI , to the extent that such changes may affect Business Associate's use or disclosure of PHI;

c. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

VI. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 C.F.R. Part 164 if done by Covered Entity.

VII. Standard Transactions

If Business Associate conducts a transaction on behalf of the Covered Entity that is covered under C.F.R. Part 162, Business Associate and it agents and subcontractors will comply with the requirements of 45 C.F.R. Part 162, to the extent applicable to the Covered Entity if the Covered Entity were conducting the transaction itself.

VIII. Security of Electronic Protected Health Information (ePHI)

a. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule;

b. Business Associate shall ensure that any agent to whom it provides ePHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect it;

c. Business Associate shall report to the Covered Entity any security incident of which it becomes aware that involved ePHI of the Covered Entity and to do so within ten (10) business days.

IX. Term and Termination

a. At termination of the contract or business arrangement, Business Associate will, if feasible, return or destroy all PHI received from, or created, maintained or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form. Business Associate agrees it will retain no copies of such PHI or, if such return or destruction is not feasible, extend the protections of its contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

b. Term. This Agreement shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created, maintained or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section;

c. Termination for Cause. Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has violated a material term of the contract, to include this Agreement and Business Associate has not cured the breach or ended the violation within thirty (30) days of the date upon which Business Associate receives notice of its breach;

d. Obligations of Business Associate Upon Termination. Upon termination of this Agreement for any reason, Business Associate shall return to Covered Entity or, if agreed to by Covered Entity, destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that the Business Associate still maintains in any form. Business associate shall retain no copies of the PHI;

e. Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

X. Effect of Termination

a. Except as provided in subparagraph IX (a) of this Agreement, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf Covered Entity. This provision shall apply to PHI that is in possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI;

b. If return or destruction of PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon notification to Covered Entity that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement for so long as Business Associate maintains such PHI.

XI. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended;

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law;

c. Policies and Procedures. The parties acknowledge that the contract or business association is subject to all applicable bylaws, rules and regulations, and written or published policies and procedures of Covered Entity regarding privacy and information handling. Business Associate agrees to be bound by such policies as may be in effect and changed from time to time as though they were a part of any contract from and after the date hereof. In addition, Business Associate agrees to adopt and comply with policies and procedures related to use and disposal of PII in compliance with C.R.S. §§ 6-1-713, 713.5, and 716.

d. Legal Requirements. The parties recognize that this Agreement is subject to and agree to comply with applicable local, state and federal statutes and rules and regulations, and orders of the courts. Any provision of applicable statutes, rules and regulations, or court orders, whether now existing or enacted or promulgated after the effective date of this Agreement, that invalidate any term of this Agreement, that are inconsistent with any term of it, or that would cause performance hereof by one or both of the parties hereto to be in violation of law shall be deemed to have superseded the terms of this Agreement and this Agreement shall be automatically amended to achieve compliance with applicable law provided, however, that if such amendment does not preserve in all material respects the underlying economic and financial arrangements between the parties, the contract may be terminated by written notice by either party;

e. Audit of Records. Covered Entity's audit of Business Associate's records, or any waiver of its right to do so does not relieve Business Associate of its responsibilities under this Agreement and any liability for violations of law or regulations;

f. Survival. The respective rights and obligations of Business Associate under Section III of this Agreement shall survive the termination of this Agreement;

g. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA requirements;

h. Assignment. Nothing expressed or implied in this Agreement is intended to confer or assign any rights, remedies, obligations or liabilities upon any person or entity other than Covered Entity and Business Associate and their respective successors and assigns.

In witness whereof, the undersigned acknowledge that they have read this Agreement and commit to be bound by its terms and conditions.

BUSINESS ASSOCIATE **Delta Dental of Colorado**	COVERED ENTITY
	_____
Signature of BA Representative	Signature of CE Representative
_____	_____
Printed Name of BA Representative	Printed Name of CE Representative
_____	_____
Date	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