DELTA DENTAL®

Please take a moment to complete this form. We will consider it, along with your group's experience, enrollment data, and any other applicable information, when setting up your account with Delta Dental.

Absence of written approval does not imply acceptance. Depending on the plan you choose, there may be minimum enrollment requirements.

If you have any questions regarding this form or any of Delta Dental's programs, please feel free to contact your Delta Dental representative.

CLIENT INFORMATION FORM

Coverage or administration for your group will not start until you receive approval in writing from Delta Dental.

Client ID Number *(for Delta Dental use only)*: _____

Client Name: _____

Plan: ☐ Michigan ☐ Indiana ☐ Ohio

Client Tax Identification/EIN #: _____

Effective Date: _____ Contract Length: ☐ 1 year ☐ 2 years. ☐ 3 years ☐ Other: _____

Physical Location: _____

City: _____ State: _____ ZIP Code: _____ County: _____

Do you need a plan that complies with the ACA's Essential Health Benefits? ☐ Yes ☐ No

If yes, what is the date of your medical plan renewal? _____

CLIENT OFFICER INFORMATION ☐ Same as Client Physical Location

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____

Contact Type: ☒ General

Telephone: (_____) _____ Ext: _____ Cell: (_____) _____

Fax: (_____) _____ Email Address: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

CLIENT UNION INFORMATION

Does client have a union? ☐ Yes ☐ No If yes, Union Local Number: _____

Union Name: _____

CLIENT CONTACT INFORMATION ☐ Same as Client Physical Location

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ Renewal ☒ Billing ☒ Mailing ☒ Materials ☒ Overage Dependent

Telephone: (_____) _____ Ext: _____ Cell: (_____) _____

Fax: (_____) _____ Email Address: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

BENEFIT MANAGER TOOLKIT REGISTRATION - CLIENT

Update your group's eligibility online, real time, using our Web-based tool, Benefit Manager Toolkit (BMT). With BMT you can enroll a new member, update existing members, view eligibility and your benefits, print dentist directories, and access flexible and convenient reports (if your group qualifies for reports). In addition, **your monthly invoice and other billing details are provided to you *exclusively* through BMT**.

Select a Client Administrator within your company and complete the information below. This administrator will be able to create and maintain your accounts, enabling immediate access for your BMT users. Delta Dental will send your administrator an email with registration information and additional instructions.

Administrator Name: _____ Title: _____

Email: _____ Phone Number: _____

Note: BMT Administrator must be an employee of the client.

BENEFIT MANAGER TOOLKIT REGISTRATION – AGENT/AGENCY

Authorize your agent/agency to update your group's eligibility online and/or view billing details online using our Web-based tool, Benefit Manager Toolkit (BMT).

If you choose to authorize access for your agent/agency, complete the information below. Delta Dental will contact users directly via encrypted email with their user ID and password (from BenefitManagerToolkitRegistration.com) once we receive confirmation from the individual authorizing access. We will only give the user this information directly.

USER INFORMATION		TYPE OF ACCESS
User ID		
NAME	COMPANY NAME (AGENCY/TPA/VENDOR)	☐ UPDATE AND VIEW ELIGIBILITY ☐ VIEW ELIGIBILITY ONLY ☐ BILLING DETAILS ☐ CLIENT KNOWLEDGE* ☐ CLAIMS DETAIL REPORTS-ASO*
TITLE	E-MAIL ADDRESS	
User ID		
NAME	COMPANY NAME (AGENCY/TPA/VENDOR)	☐ UPDATE AND VIEW ELIGIBILITY ☐ VIEW ELIGIBILITY ONLY ☐ BILLING DETAILS ☐ CLIENT KNOWLEDGE* ☐ CLAIMS DETAIL REPORTS-ASO*
TITLE	E-MAIL ADDRESS	

Client Knowledge and Claims Detail Reports may not be available to your group

I certify that the people listed above require access to the benefit manager toolkit as indicated.

Administrator Name: _____ Title: _____

Authorized Signature: _____ Date: _____

ADDITIONAL INFORMATION

Prior Carrier? ☐ Yes ☐ No *(if yes, please provide copy of invoice or benefit summary from prior carrier)*

Name of Prior Carrier: _____

Is this a dual option arrangement? ☐ Yes ☐ No

Bill Type (How would you like to receive your bill?): ☐ Mail ☐ Email Notification Only

SUBCLIENT INFORMATION

☐ Same as Client Physical Location

1. Subclient Name: _____

   Subclient Number(s): _____ Subclient TIN/EIN, if different: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ County: _____

☐ Same as Client Physical Location

2. Subclient Name: _____

   Subclient Number(s): _____ Subclient TIN/EIN, if different: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ County: _____

☐ Same as Client Physical Location

3. Subclient Name: _____

   Subclient Number(s): _____ Subclient TIN/EIN, if different: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ County: _____

FOR AGENTS ONLY

Agent Name: _____

Agency Name: _____

Checks to: ☐ Agency ☐ Agent

Social Security Number: _____ TIN: _____

YOUR SOCIAL SECURITY NUMBER IS REQUIRED BY THE STATE FOR APPOINTMENT.

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: (_____) _____ Fax Number: (_____) _____

Cell Phone:(_____) _____ Email Address: _____

Percentage of Commission: _____ (if more than one agent)

☐ Standard ☐ Flat _____%

STANDARD COMMISSION SCHEDULE		
	GROUP SIZE	**STANDARD PERCENT OF PREMIUM OR ADMINISTRATIVE FEES & CLAIMS PAID**
☐	1 to 24 subscribers	10.00%
☐	25 to 49 subscribers	7.75%
☐	50 to 99 subscribers	6.25%
☐	100 to 199 subscribers	4.75%

Start Date: _____

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Delta Dental in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Delta Dental. This requirement is a condition to eligibility for receiving compensation under Delta Dental's agency/agent compensation program as described in Delta Dental's Agency/Agent Agreement. Delta Dental will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this form I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Delta Dental related to the client's purchase of a Delta Dental benefit plan.

Agent's Signature: _____ Date: _____

ELIGIBILITY AGE LIMITS FOR DEPENDENT CHILD(REN)

What age does dependent child(ren) coverage end (i.e., 24, 25, 26)? _____

When does dependent child(ren) coverage end? ☐ To Birthdate ☐ End of Month ☐ End of Year

COB PROCESSING INFORMATION

Payment Option Type: ☒ Standard ☐ Carve-Out/Non-duplication

Support Internal COB (Spouses with the same employer can cover each other): Yes ☐ No ☐

Support External COB (Spouses with different employers can cover each other): Yes ☐ No ☐

SUBSCRIBER DEFINITION (by subclient, if applicable)

Example: *All full-time employees of the Contractor working at least 30 hours per week.*

NEW EMPLOYEE/MEMBER WAITING PERIOD

Example: *On the first day of the month following 90 days of employment*

TERMINATION LANGUAGE (when should coverage end)

☐ Term on Date of Termination ☐ Term at End of Month

NOTES:

DOMESTIC PARTNER COVERAGE

Domestic Partner Covered? Yes ☐ No ☐

EMPLOYEE PARTICIPATION LIST VERIFICATION

I verify that all of the individuals eligible for dental coverage have been given the opportunity to enroll in the dental plan offered by Delta Dental. For the undersigned employer, I certify that the number of eligible and enrolled employees for this dental plan as of this date is:

Status	Number Eligible for Dental	Number Enrolled
Full-Time Employees		
Part-Time Employees		
Retirees		

If a segment has members but they are not eligible for coverage, enter zero for the number eligible.

*Please confirm the percentage that the **employer** contributes for employees and dependents:*

_____% **Employer** Contribution for Employee

_____% **Employer** Contribution for Dependents

AGREEMENT

The undersigned client hereby adopts and subscribes to the terms and provisions in this form and certifies to the best of his/her knowledge and belief, all the responses are true, correct and complete. It is agreed that the client has 15 days from the date of delivery of the contract to return the contract to Delta Dental's corporate headquarters for a full refund. If the client exercises this right, the contract will terminate on the effective date as if no coverage were ever in force, and all money received will be returned.

In addition to the commissions and/or fees identified specifically for your plan, the Agency/Agent may qualify for additional compensation payments from Delta Dental related to your purchase of a Delta Dental benefit plan. This additional compensation is not charged to your plan. The Agent/Agency of Record has full authority to act on the client's behalf in all matters concerning the client's dental benefits administration, including but not limited to contractual matters and changes to the client's contract.

Misrepresentation or fraud will cause your contract to be null and void from the start and may be violating state law.

Payment of the first month's rate for the proposed Delta Dental program(s) and a copy of the proposal must accompany this form.

Signature of Client's Authorized Official:_____ Date:_____

Printed Name: _____

Title: _____

Signature of Agent or Delta Dental Representative: _____ Date: _____

Amount Received: $_____ Check Number: _____

HIPAA Group Health Plan Certification

The _____ Group Health Plan ("Plan"), through its fiduciary, 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 have been amended, as required by 45 CFR 164.504(f) of HIPAA, to incorporate the following provisions and you, as the Plan Sponsor, agreed to:

    a. Not use or further disclose health information protected under HIPAA ("PHI") other than as permitted or required by the plan documents or as required by law;
    b. Ensure that any agents, including subcontractors, to whom you provide PHI agree to the same restrictions and conditions that apply to you with respect to such information;
    c. Not use or disclose PHI for employment-related actions and decisions;
    d. Not use or disclose PHI in connection with any other benefit or employee benefit plan;
    e. Report to Plan's designee any PHI use or disclosure that you become aware of that is inconsistent with the uses or disclosures provided for;
    f. Make PHI available to an individual based on HIPAA's access requirements;
    g. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
    h. Make available the information required to provide an accounting of disclosures;
    i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U. S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
    j. Ensure that adequate separation between the Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and
    k. If feasible, return or destroy all PHI received from the Plan that you, as the Plan Sponsor, still maintain 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, you will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

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

Printed Name of Plan Fiduciary Representative	Delta Dental Group Number(s)
Signature of Plan Fiduciary Representative	Date

OR We decline to sign this Group Health Plan Certification and will not create, maintain, receive or access PHI for our group members.

Printed Name of Plan Fiduciary Representative	Delta Dental Group Number(s)
Signature of Plan Fiduciary Representative	Date

Please fill in the name of your group health plan, sign and date this Certification, and return one original to Delta Dental, P.O. Box 30416, Lansing, MI 48909.