

Electronic Group Information Form 'How To' Guide

October 2021

Roosevelt
simple. seamless. smart.

Group Information Form

Welcome to Delta Dental

Thank you for taking a few moments
to fill out this Group Information Form.

This site is optimized for Microsoft Edge, Google Chrome and Apple Safari.

Firefox, Opera, Vivaldi and other HTML5 browsers *may* also work,
but with decreased performance and slower speeds.

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[Click Here for the Form](#)

1. Click “Click Here for the From” to open the Group Information Form

Group Information

Page Help

Next Page

* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

* Physical Address

* City

* State

(Choose)

* Zip Code #####

* County

Please Note: P.O. Boxes are not acceptable for client location.

* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

7/1/2021

Contract Length:

2 Years

Group Type:

Risk

Agent Name:

Save and Finish Later

Next Page

Form Progress

Group Information

Group Contact Information

Benefit Manager Toolkit

Prior Carrier

Subgroup Information

Eligibility Age Limits

Coordination of Benefits

Subscriber Definition

Member Waiting Period

Termination Language

HIPAA Group Plan Cert.

Summary - Form Data

Summary - Documents

Submission

(14 pages)

2. Complete all fields on the Group Information Page

Group Information

Page Help ⓘNext Page

* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

* Physical Address

* City

* State

(Choose) ▾

* Zip Code #####

* County

Please Note: P.O. Boxes are not acceptable for client location.

* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

Save and Finish Later

Next Page

Form Progress

● Group Information

● Group Contact Information

● Benefit Manager Toolkit

● Prior Carrier

● Subgroup Information

● Eligibility Age Limits

● Coordination of Benefits

● Subscriber Definition

● Member Waiting Period

● Termination Language

● HIPAA Group Plan Cert.

● Summary - Form Data

● Summary - Documents

● Submission

(14 pages)

3. Review the non-editable gray fields and contact your Sales Rep if anything is incorrect

Group Information

Page Help ⓘNext Page

* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

* Physical Address

* City

* State

(Choose) ▾

* Zip Code #####

* County

Please Note: P.O. Boxes are not acceptable for client location.

* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

Save and Finish Later

Next Page

Form Progress

● Group Information

● Group Contact Information

● Benefit Manager Toolkit

● Prior Carrier

● Subgroup Information

● Eligibility Age Limits

● Coordination of Benefits

● Subscriber Definition

● Member Waiting Period

● Termination Language

● HIPAA Group Plan Cert.

● Summary - Form Data

● Summary - Documents

● Submission

(14 pages)

4. At any point while filling out the form, you can save and finish the form later. Use the same link to access the form again

Group Information

Page Help ⓘ

Next Page

* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

* Physical Address

* City

* State

(Choose) ▼

* Zip Code #####

* County

Please Note: P.O. Boxes are not acceptable for client location.

* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

Save and Finish Later

Next Page

Form Progress

● Group Information

● Group Contact Information

● Benefit Manager Toolkit

● Prior Carrier

● Subgroup Information

● Eligibility Age Limits

● Coordination of Benefits

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● Member Waiting Period

● Termination Language

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● Summary - Form Data

● Summary - Documents

● Submission

(14 pages)

5. Click “Next Page” to move to the next page. Moving to the next page will also save your information

Contact Type Selection

- Add contacts in the below section by clicking the add contact button
- Once all contact(s) have been added, please select the Contact Type for your contact
- Only one contact name is allowed per Contact Type

Contact Role Definitions:

General Contact - This contact will receive a second collection letter if the Billing Contact collection letter goes unanswered.

Renewal Contact - This contact will receive the contract and renewal documents. A Renewal Contact is required for documents, if there is not a renewal contact listed the address on the documents will print blank.

Billing Contact - This contact will receive bills and other materials related to billing. We must have an email address for this contact to send bills via email. This contact also receives an email notification that the invoice is available on Benefit Manager Toolkit (BMT). However, if the client receives their Delta Dental bill in the mail, this is the name and address of the individual receiving that information.

Materials Contact - This contact will receive group materials, such as pamphlets, certificates, summaries, etc. Note: A PO Box cannot be used for the materials contact, and a street address must be entered for this contact type.

Mailing Contact - This contact will receive general, mass mailing information.

Overage Dependent Contact - This contact will receive the email notification that the overage dependent report is ready to be viewed in BMT. This contact type requires an email address.

6. Review the contact role definitions and scroll down to enter contacts

Contacts

+ Add Contact

Name	Address	Preferred Ph#/Email

Legend: Edit Delete Set All Roles

Roles

* General

Choose...

* Renewal

Choose...

* Billing

Choose...

* Mailing

Choose...

* Materials

(no P.O. Boxes)

Choose...

* Overage Dependent

Choose...

* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No

Save and Finish Later

Previous Page

Next Page

7. Use the green “Add Contact” button to add a contact

Group Contact Information

- Add contact
- Once all
- Only one

General Contact
Renewal Contact
there is not a re
Billing Contact
contact to send
Toolkit (BMT). F
receiving that in
Materials Cont
cannot be used
Mailing Contac
Overage Depen
viewed in BMT.

Contacts

Name

Legend: Edit Delete Set All Roles

Edit Contact

Special Note: Contacts for the Materials Role may not have a P.O. Box.

Contact Name:

Salutation * First Name * Last Name Suffix

Select... [] [] []

Title

[]

Address Details:

Street Apt/Suite

123 Tester Street []

City State Zip #####

Middle Michigan 12345

Contact Methods:

Required Method * Preferred Work Email

Work Email []

Second Method

Cancel Save

Group Contact Information

- Add contact
- Once all
- Only one

General Contact
Renewal Contact
there is not a re
Billing Contact
contact to send
Toolkit (BMT). R
receiving that in
Materials Cont
cannot be used
Mailing Contac
Overage Depe
viewed in BMT.

Contacts

Name

Edit Contact

Special Note: Contacts for the Materials Role may not have a P.O. Box.

Contact Name:

Salutation * First Name * Last Name Suffix

Select... [] [] []

Title

[]

Address Details:

Street Apt/Suite

123 Tester Street []

City State Zip #####

Middle Michigan [] 12345

Contact Methods:

Required Method * Preferred Work Email

Work Email []

Cancel Save

9. The address will default to the Group address. Confirm that this is accurate or update to the correct address

Group Contact Information

- Add contact
- Once all
- Only one

General Contact
Renewal Contact
there is not a re
Billing Contact
contact to send
Toolkit (BMT).
receiving that in
Materials Cont
cannot be used
Mailing Contact
Overage Depe
viewed in BMT.

Contacts

Name

Legend: Edit Delete Set All Roles

Edit Contact

Special Note: Contacts for the Materials Role may not have a P.O. Box.

Contact Name:

Salutation * First Name * Last Name Suffix

Select...

Title

Address Details:

Street Apt/Suite

123 Tester Street

City State Zip #####

Middle Michigan 12345

Contact Methods:

Required Method * Preferred Work Email

Work Email

Cancel Save

Edit Contact

Special Note: Contacts for the Materials Role may not have a P.O. Box.

Contact Name:

Salutation

Select...

* First Name

* Last Name

Suffix

Title

Address Details:

Street

123 Tester Street

Apt/Suite

City

Middle

State

Michigan

Zip #####

12345

Contact Methods:

Required Method

Work Email

* Preferred Work Email

Second Method

Cancel

Save

11. Click “Save” to save the contact. You will be able to make edits to any saved contacts

Contacts

+ Add Contact

Name	Address	Prefered Ph#/Email	
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	

Legend:

 Edit

 Delete

 Set All Roles

Roles

* General

Choose...

* Renewal

Choose...

* Billing

Choose...

* Mailing

Choose...

* Materials

(no P.O. Boxes) ?

Choose...

* Overage Dependent

Choose...

* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No

Save and Finish Later

Previous Page

Next Page

12. To edit an existing contact, click the pencil icon. To delete a contact, click the garbage can icon. To set that contact as all roles, click the arrows

Contacts

+ Add Contact

Name	Address	Preferred Ph#/Email
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com

Legend:

Edit

Delete

» Set All Roles

Roles

* General

John Smith

* Renewal

Jane Brown

* Billing

John Smith

* Mailing

John Smith

* Materials

(no P.O. Boxes)

John Smith

Choose...

John Smith

Jane Brown

* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No

Save and Finish Later

Previous Page

Next Page

13. Set a contact to each role by using the arrows or the drop down under each role

Contacts

+ Add Contact

Name	Address	Prefered Ph#/Email	
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:

 Edit

 Delete

 Set All Roles

Roles

* General

Choose...

* Renewal

Choose...

* Billing

Choose...

* Mailing

Choose...

* Materials

(no P.O. Boxes) 

Choose...

* Overage Dependent

Choose...

* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No

Save and Finish Later

Previous Page

Next Page

14. Indicate if you need additional emails notified that a bill is available to be viewed online

John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:  Edit  Delete  Set All Roles

John Smith

* Renewal
Jane Brown

* Billing
John Smith

* Mailing
John Smith

* Materials (no P.O. Boxes) 
John Smith

* Overage Dependent
John Smith

* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

Yes

* Additional Billing Emails (please enter with a comma in between each email, i.e. billing@company.com, jane@company.com).

accounting@company.com, admin@company.com

Save and Finish Later

Previous Page

Next Page

15. If yes, add the billing emails that should be notified with a comma between each one

John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:  Edit  Delete  Set All Roles

John Smith

* Renewal
Jane Brown

* Billing
John Smith

* Mailing
John Smith

* Materials (no P.O. Boxes) 
John Smith

* Overage Dependent
John Smith

* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

Yes

* Additional Billing Emails (please enter with a comma in between each email, i.e. billing@company.com, jane@company.com).

accounting@company.com, admin@company.com

Save and Finish Later

Previous Page

Next Page

16. Once complete, click “Next Page” to move to the next page

Select one individual within your company to be your Group Administrator and complete the information below. This administrator will be able to create and maintain your accounts as well as create BMT user accounts for additional individuals within your company. Delta Dental will send your administrator an email with registration information and additional instructions.

BMT Administrator must be an employee of the client

Please define who will be the administrator for your accounts:

* Administrator's First Name:

John

* Administrator's Last Name :

Smith

* Administrator's Title

Benefits Manager

* Email:

johnsmith@company.com

* Phone Number: XXX-XXX-XXXX

123-456-7891

17. Complete each field to add the BMT administrator

Note: the BMT administrator must be an individual within the company

* I authorize that the assigned Agent/Agency (including General Agents) requires access to the Benefit Manager Toolkit as indicated.

Yes

[PLEASE CLICK HERE TO GET A PREVIEW OF THE BENEFIT MANAGER TOOLKIT](#)

What is BMT?

With the Benefit Manager Toolkit® (BMT), benefit managers and third-party administrators can:

- Get real-time benefit and eligibility information 24/7
- Access billing details
- Manage your groups eligibility by entering, editing and terminating members
- Streamline your benefits management process
- Download dentist directories in a printable format

Save and Finish Later

Previous Page

Next Page

18. If you have an agent, indicate if you want to give your assigned agent/agency access to BMT

* I authorize that the assigned Agent/Agency (including General Agents) requires access to the Benefit Manager Toolkit as indicated.

Yes

[PLEASE CLICK HERE TO GET A PREVIEW OF THE BENEFIT MANAGER TOOLKIT](#)

What is BMT?

With the Benefit Manager Toolkit® (BMT), benefit managers and third-party administrators can:

- Get real-time benefit and eligibility information 24/7
- Access billing details
- Manage your groups eligibility by entering, editing and terminating members
- Streamline your benefits management process
- Download dentist directories in a printable format

Save and Finish Later

Previous Page

Next Page

19. Once complete, click “Next Page” to move to the next page

Prior Carrier

Page Help ⓘ

Previous Page

Next Page

* Do you have a prior carrier?

Yes

* Prior carrier name:

Please attach a copy of your invoice or benefit summary from your prior carrier.

Prior carrier documents

No Files Attached.

 Click to Upload a File

Save and Finish

Previous Page

Next Page

20. If you have Prior Carrier, type in the prior carrier's name and attach a copy of your invoice or benefit summary

Prior Carrier

Page Help 

Previous Page

Next Page

* Do you have a prior carrier?

No

Save and Finish

Previous Page

Next Page

21. If you do not have a Prior Carrier, select “No” and move on to the next page

Please enter your Plan Information and the associated Subgroup information in the section below.

*Information may have been pre-filled by your Sales Representative.
You can modify the Plan name and Subgroup names and numbers below.*

Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.

See downloadable document for Subgroup structure examples

Plans

High Plan

 Edit Plan Name

* Subgroup #

* Subgroup Name

+ Add

0001

Subgroup name



22. Review the plans and subgroups that have been added for your group

Subgroup Information

[Page Help](#) [Previous Page](#)[Next Page](#)

Please enter your Plan Information and the associated Subgroup information in the section below.

*Information may have been pre-filled by your Sales Representative.
You can modify the Plan name and Subgroup names and numbers below.*

Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.

See downloadable document for Subgroup structure examples

Plans

High Plan

[Edit Plan Name](#)

* Subgroup # * Subgroup Name

[+ Add](#)

0001

Subgroup name



23. Edit the plan name with the “Edit Plan Name” button or click into the subgroup name or subgroup number to edit the subgroup name or subgroup number

Subgroup Information

Please enter your Plan Information and the associated Subgroup information in the section below.

*Information may have been pre-filled by your Sales Representative.
You can modify the Plan name and Subgroup names and numbers below.*

Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.

See downloadable document for Subgroup structure examples

Plans

High Plan

 Edit Plan Name

* Subgroup #

* Subgroup Name

0001

Subgroup name

 Add



24. If needed, add a subgroup with the green “Add” button or delete a subgroup with the red trash can button

Plans

High Plan

 Edit Plan Name

* Subgroup # * Subgroup Name

 Add

0001

Subgroup name



* Is Subgroup contact information different from what
was previously entered?

No

Save and Finish Later

Previous Page

Next Page

25. Indicate if the subgroups have different contact information (address, etc) than the group

0001

Subgroup name



* Is Subgroup contact information different from what was previously entered?

Yes

[Click here to access sample Subgroup spreadsheet. Once updated please upload below.](#)

Please upload Subgroup spreadsheet if applicable here.

No Files Attached.



Upload Files

Or drop files

*

Save and Finish Later

Previous Page

Next Page

26. If the subgroups have different contact information, upload a subgroup spreadsheet that includes contact and other information by subgroup

0001

Subgroup name



* Is Subgroup contact information different from what was previously entered?

Yes



[Click here to access sample Subgroup spreadsheet. Once updated please upload below.](#)

Please upload Subgroup spreadsheet if applicable here.

No Files Attached.

*



Upload Files

Or drop files

Save and Finish Later

Previous Page

Next Page

27. Once complete, click “Next Page” to move to the next page

Eligibility Age Limits for Dependent Child(ren)

Page Help 

Previous Page

Next Page

* Are your dependent children covered to age 26?

Yes



* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached



Save and Finish Later

Previous Page

Next Page

28. Indicate if dependent children are covered to age 26

Eligibility Age Limits for Dependent Child(ren)

Page Help 

Previous Page

Next Page

* Are your dependent children covered to age 26?

Yes

* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

Previous Page

Next Page

29. If dependent children are covered to age 26, select when coverage ends

Eligibility Age Limits for Dependent Child(ren)

Page Help 

Previous Page

Next Page

* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

Previous Page

Next Page

30. If dependent children are not covered to age 26, indicate ages for each dependent

Eligibility Age Limits for Dependent Child(ren)

Page Help 

Previous Page

Next Page

* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

19

20

21

22

23

24

25

26

IRS Max Age

23

* When does dependent child(ren) end of year that the age limit applies?

End of Year that the age limit applies

Save and Finish Later

Previous Page

Next Page

31. The age limits are selected from each drop down. The Child Max Age selected should be lower than the student max age, which should be lower than the IRS max age

Eligibility Age Limits for Dependent Child(ren)

[Page Help](#) [Previous Page](#)[Next Page](#)

* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

[Save and Finish Later](#)[Previous Page](#)[Next Page](#)

32. Once age limits have been indicated, select when coverage ends

Eligibility Age Limits for Dependent Child(ren)

Page Help 

Previous Page

Next Page

* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

(Choose)

To Birthdate that the age limit above has been reached

End Of Month that the age limit above has been reached

End of Year that the age limit above has been reached

End of Benefit Period that the age limit above has been reached

Previous Page

Next Page

33. Select one of the coverage end options from the drop down list

Eligibility Age Limits for Dependent Child(ren)

Page Help 

Previous Page

Next Page

* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

Previous Page

Next Page

34. Once complete, click “Next Page” to move to the next page

* Payment Option Type:

Standard 

For a definition of payment types, see Page Help

* Support Internal COB - Plan will allow spouses with same employer to cover each other:

No 

For additional information on Internal COB, see Page Help

* Support External COB - Plan will allow spouses with different employers to cover each other:

Yes 

For additional information on External COB, see Page Help

* Domestic Partner Coverage:

No 

Save and Finish Later

Previous Page

Next Page

PAGE HELP

Please fill out each field to the best of your ability. You will not be able to move forward until you have completed each required field. Defaults have been selected for the most common answer, but you may change any selection on the defaulted field. Please contact your Sales Rep if you have any questions throughout the process.

Coordination of Benefits (COB) is a procedure for paying health care expenses when people are covered by more than one plan. The goal of COB is to make sure the combined payments of the plan do not exceed the amount of your actual bills.

- ***This is internal COB "No" definition: Coordination of Benefits*** - If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.
- ***This is internal COB "Yes" definition: Coordination of Benefits*** - If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your dependent Children may be enrolled on both you and your Spouse's application as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Support External COB: Plan will allow spouses with different employers can cover each other.

Payment Option Types definitions:

Close

36. The Page Help section has definitions of COB terms. Click "Close" to return to the form

Coordination of Benefits (COB) Processing Information

[Page Help](#) ⓘ[Previous Page](#)[Next Page](#)

* Payment Option Type:

Standard

For a definition of payment types, see Page Help

* Support Internal COB - Plan will allow spouses with same employer to cover each other:

No

For additional information on Internal COB, see Page Help

* Support External COB - Plan will allow spouses with different employers to cover each other:

Yes

For additional information on External COB, see Page Help

* Domestic Partner Coverage:

No

[Save and Finish Later](#)[Previous Page](#)[Next Page](#)

37. Once complete, click “Next Page” to move to the next page

Subscriber Definition

Page Help 

Previous Page

Next Page

The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page.

Subscriber Definition Example: All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable.

* Who is eligible for benefits?

All full-time employees of the Contractor working at least X hours per



* Minimum number of hours per week full-time employees who choose the dental plan and COBRA enrollees if applicable:

30



38. Indicate who is eligible for benefits and the minimum number of hours per week needed for full-time employees to enroll in dental benefits

The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page.

Subscriber Definition Example: All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable.

*Who is eligible for benefits?

All full-time employees of the Contractor working at least X hours per

(Choose)

All full-time employees of the Contractor working at least X hours per

Other

39. If you need to create your own definition, select “Other”

Subscriber Definition

Page Help 

Previous Page

Next Page

The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page.

Subscriber Definition Example: All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable.

* Who is eligible for benefits?

Other

* Other subscriber definition:

Write definition here

40. Write in the group's desired subscriber definition in the other box

Employer Participation 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 of this date:

* Number of Full-Time Employees ELIGIBLE for Dental:

* Number of Part-Time Employees ELIGIBLE for Dental:

* Number of Retired Employees ELIGIBLE for Dental:

* Number of Full-Time Employees ENROLLED for Dental:

* Number of Part-Time Employees ENROLLED for Dental:

* Number of Retired Employees ENROLLED for Dental:

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

[Save and Finish Later](#)

[Previous Page](#)

[Next Page](#)

41. Review the Employer Participation Verification section and input the number of employees (full time, part-time, and retired) eligible and enrolled for Dental. Once complete, click “Next Page”

New Employee/Member Waiting Period

Page Help 

Previous Page

Next Page

* When does coverage begin for a new employee?

Coverage begins on the date of hire



Save and Finish Later

Previous Page

Next Page

42. Indicate when coverage begins for a new employee

New Employee/Member Waiting Period

Page Help 

Previous Page

Next Page

* When does coverage begin for a new employee?

Coverage begins on the date of hire

(Choose)

Coverage begins on the date of hire

Coverage begins X days after hire

Coverage begins in the first day of the month following X days of employment

Coverage begins on the first day of the month following the date of hire

Other (please fill in below)

Previous Page

Next Page

43. Select an option from the drop down or pick Other to add your own definition

New Employee/Member Waiting Period

Page Help 

Previous Page

Next Page

* When does coverage begin for a new employee?

Other (please fill in below)



* Other waiting period definition:

Write definition here

Save and Finish Later

Previous Page

Next Page

44. If other, write a definition in the other box

New Employee/Member Waiting Period

Page Help 

Previous Page

Next Page

* When does coverage begin for a new employee?

Coverage begins on the date of hire



Save and Finish Later

Previous Page

Next Page

45. Once complete, click “Next Page” to move to the next page

Termination Language

Page Help 

Previous Page

Next Page

* When an employee is no longer at your organization, when does their coverage end?

At end of the month following termination



Save and Finish Later

Previous Page

Next Page

46. Indicate when coverage ends when an employee is no longer with your organization

Termination Language

Page Help 

Previous Page

Next Page

*When an employee is no longer at your organization, when does their coverage end?

Other

(Choose)

At end of the month following termination

Date of termination

Other

Save and Finish Later

Previous Page

Next Page

47. Select an option from the drop down or pick "Other" to add your own definition

Termination Language

Page Help 

Previous Page

Next Page

* When an employee is no longer at your organization, when does their coverage end?

Other

* Other Termination Language:

Write other language here

Save and Finish Later

Previous Page

Next Page

48. If other, write in your own termination language

Termination Language

Page Help 

Previous Page

Next Page

* When an employee is no longer at your organization, when does their coverage end?

At end of the month following termination



Save and Finish Later

Previous Page

Next Page

49. Once complete, click “Next Page” to move to the next page

Group Information Form (eGIF)

HIPAA Group Plan Certification

PDF 

Page Help 

Previous Page

Next Page

The [Client Name Goes Here] 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 and 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 the 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 Plan that you, as Plan Sponsor, still maintain any form and retain no copies of such PHI when no longer needed for the specific disclosure purpose. If return or destruction is not feasible, you will limit further uses and disclosures to those purposes that make the return destruction infeasible.

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

Accept



Printed Name of Plan Fiduciary Representative:

Test



***The field above does not qualify as an electronic signature;
a signature form must be downloaded, signed, and uploaded below.***

[Click here to download Signature Form. Once signed please click the attach file button below to complete the HIPAA Group Plan Certification.](#)

50. Note for a Risk Group you will need to accept or reject HIPAA agreement. If accepted t, you must download, sign, and upload the form.

Summary - Form Data

Page Help ⓘ

Previous Page

Next Page

Please review All Information for Accuracy prior to submitting.

Name and Address

Legal Business Name:

Group Name

Tax ID:

123456789

Address:

123 Main St

City:

Lansing

State:

Michigan

Zip Code:

00000

County:

Ingham

Effective Date:

5/27/2021



Form Progress

- ✓ Group Information
- ✓ Group Contact Information
- ✓ Benefit Manager Toolkit
- ✓ Prior Carrier
- ✓ Subgroup Information
- ✓ Eligibility Age Limits
- ✓ Coordination of Benefits
- ✓ Subscriber Definition
- ✓ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- Summary - Form Data**
- ✓ Summary - Documents
- Submission

(14 pages)

51. Once you have completed all pages, review the information on the Summary page. You can edit some information from this page, or move back to a previous page to make updates

* Subgroup # * Subgroup Name

+ Add

1001

Subgroup name



Plan

 Edit Plan Name

* Subgroup # * Subgroup Name

+ Add

2001

Subgroup name



Save and Finish Later

Previous Page

Next Page

52. Once complete, click “Next Page” to move to the next page

Summary -- Attached Documents

Page Help 

Previous Page

Next Page

**** Please confirm you have attached all the correct documents to the form below ****

In addition to any documents previously loaded the following document templates are being provided for your convenience but are not required:

Enrollment Spreadsheet: This form is to be completed for each employee (and his/her dependents) that chooses to enroll.

Enrollment form: This form is an optional form that can be used for enrollment

Direct Debit Form: This form is an optional form if the group would like their monthly premiums withdrawn electronically

If you choose to fill out any of above documents, please be sure to attach them to your Group Intake Form by using the Upload Document button below.

[Direct Debit Authorization Form](#)

[Enrollment Form](#)

[Enrollment Spreadsheet](#)

Form Progress

-  Group Information
-  Group Contact Information
-  Benefit Manager Toolkit
-  Prior Carrier
-  Subgroup Information
-  Eligibility Age Limits
-  Coordination of Benefits
-  Subscriber Definition
-  Member Waiting Period
-  Termination Language
-  HIPAA Group Plan Cert.
-  Summary - Form Data
-  **Summary - Documents**
-  Submission

(14 pages)

53. After all information has been reviewed, attach any documents that need to be included with your Group Information Form. Optional documents are available to be downloaded from this page

If you choose to fill out any of above documents, please be sure to attach them to your Group Intake Form by using the Upload Document button below.

[Direct Debit Authorization Form](#)

[Enrollment Form](#)

[Enrollment Spreadsheet](#)

Documents

No Files Attached.



Upload Files

Or drop files

Save and Finish Later

Previous Page

Next Page

- ✓ Subscriber Definition
- ✓ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- Summary - Documents**
- Submission

(14 pages)

If you choose to fill out any of above documents, please be sure to attach them to your Group Intake Form by using the Upload Document button below.

[Direct Debit Authorization Form](#)

[Enrollment Form](#)

[Enrollment Spreadsheet](#)

Documents

No Files Attached.



Upload Files

Or drop files

Save and Finish Later

Previous Page

Next Page

- ✓ Subscriber Definition
- ✓ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- Summary - Documents**
- Submission

(14 pages)

55. Once complete, click “Next Page” to move to the next page

Confirmation and Submission

Page Help ⓘ

Previous Page

If the green "**Finish & Download PDF Copy**" button is enabled, then:

Congratulations, you are now ready to complete this form.

Clicking that button will submit this form to your Sales Representative and automatically open a PDF copy of this form for you to save and keep for future reference.

Once this form is submitted, your access to this form will *no longer be valid*. Your Sales Representative will review your information and may contact you with any question.

Save and Finish Later

Finish & Download PDF Copy

Previous Page

Form Progress

✓

Group Information

✓

Group Contact Information

✓

Benefit Manager Toolkit

✓

Prior Carrier

✓

Subgroup Information

✓

Eligibility Age Limits

✓

Coordination of Benefits

✓

Subscriber Definition

⊘

Member Waiting Period

✓

Termination Language

✓

HIPAA Group Plan Cert.

✓

Summary - Form Data

✓

Summary - Documents

⊙

Submission

1 issues

(14 pages)

56. If the “Finish & Download PDF Copy” button is gray, go back to the page with an issue to compete it

Confirmation and Submission

[Page Help](#)

[Previous Page](#)

If the green **"Finish & Download PDF Copy"** button is enabled, then:

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[Finish & Download PDF Copy](#)

[Previous Page](#)

Form Progress

Group Information

Group Contact Information

Benefit Manager Toolkit

Prior Carrier

Subgroup Information

Eligibility Age Limits

Coordination of Benefits

Subscriber Definition

Member Waiting Period

Termination Language

HIPAA Group Plan Cert.

Summary - Form Data

Summary - Documents

Submission

(14 pages)

57. Once all pages have been completed, the “Finish & Download PDF Copy” is green, and you have all green checks on the right-hand menu, you are ready to submit

Confirmation and Submission

Page Help ⓘ

Previous Page

If the green **"Finish & Download PDF Copy"** button is enabled, then:

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Save and Finish Later

Finish & Download PDF Copy

Previous Page

Form Progress

✓

Group Information

✓

Group Contact Information

✓

Benefit Manager Toolkit

✓

Prior Carrier

✓

Subgroup Information

✓

Eligibility Age Limits

✓

Coordination of Benefits

✓

Subscriber Definition

✓

Member Waiting Period

✓

Termination Language

✓

HIPAA Group Plan Cert.

✓

Summary - Form Data

✓

Summary - Documents

Submission

(14 pages)

58. If you are not ready to submit, use the “Save and Finish Later” button to save all of your information. You can return to the form at any time using the same link

Confirmation and Submission

[Page Help](#)[Previous Page](#)

If the green "**Finish & Download PDF Copy**" button is enabled, then:

Congratulations, you are now ready to complete this form.

Clicking that button will submit this form to your Sales Representative and automatically open a PDF copy of this form for you to save and keep for future reference.

Once this form is submitted, your access to this form will *no longer be valid*.
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[Save and Finish Later](#)[Finish & Download PDF Copy](#)[Previous Page](#)

Form Progress

- ✓ Group Information
- ✓ Group Contact Information
- ✓ Benefit Manager Toolkit
- ✓ Prior Carrier
- ✓ Subgroup Information
- ✓ Eligibility Age Limits
- ✓ Coordination of Benefits
- ✓ Subscriber Definition
- ✓ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- ✓ Summary - Documents
- Submission**

(14 pages)

59. Once you are ready to submit, click “Finish & Download PDF copy” to submit the form



1

2

3

Delta Dental's - New Group Process

Group Information Form (eGIF)

Powered by
Roosevelt

Group Information

Legal Business Name

test test

Enter the Company Name as you would like it to appear on the contract.

Physical Address

test

City

test

State

Michigan

Zip Code #####

11111

County

test

Group Name:

Plan:

Delta Dental of Michigan

Effective Date:

6/10/2021

Contract Length:

2 Years

Group Type:

Risk

Agent Name:

Please Note: P.O. Boxes are not acceptable for client location.

Group Tax Identification/EIN #: (XXXXXXXX)

123456789

60. You have submitted the Group Information Form. You can now download a PDF of the form for your records. Reach out to your Sales Rep if you have any questions.