DELTA DENTAL®

www.deltadentalmn.org

July 2015

Dear Benefits Administrator,

Thank you for considering a Delta Dental plan for your employees. For more than 45 years, Delta Dental of Minnesota has been the trusted hometown dental benefits carrier. We are pleased to be endorsed as the dental benefits vendor of choice by the Minnesota Service Cooperatives. We offer easy-to-use, cost-effective dental benefit plans, access to Minnesota's largest dentist networks and a commitment to top quality customer service.

We are pleased to offer a choice of Voluntary and also new this year, Contributory, dental plans in conjunction with National Insurance Services (NIS), our selected marketing partner. NIS has a longstanding commitment of providing products and services to the Minnesota educational community

Enclosed you will find four Dental Plan Summaries for your consideration. Each Plan comes with two Options that offer different coverage levels, deductibles, lifetime maximums and monthly premiums to meet the varying needs your employees. All plans offer solid coverage to meet your employees' dental needs and offer access to the Delta Dental Premier® and Delta Dental PPO networks – Minnesota's largest dentist networks. **Plan premiums are established on July 1st and are effective through June 30th for new group and renewals rates. Premiums are guaranteed for 12 months for all individual groups.**

Here are a few easy steps to get started:

1. First, select the Dental Plan you wish to offer employees. Each group can only select one of the four dental plans—Dental Plan A, Dental Plan B, Dental Plan C, Dental Plan D, or Dental Plan D with or without Orthodontics— to offer to all their employees. Plan D is available on a Voluntary or Contributory basis. Groups cannot select more than one plan.
2. Please provide each eligible employee a copy of the Dental Plan selected by the school along with a copy of the enclosed Member Enrollment Form. After reviewing the Dental Plan employees must select either Option 1 or Option 2, based on their individual needs.
3. Then, employees must complete the Member Enrollment Form. A toll-free number (listed on the Dental Plan) is available to help answer any question you or your employees may have.
4. At the end of the enrollment period, please collect the completed and signed Member Enrollment Forms. Please ensure that all fields are completed. Any incomplete forms may delay enrollment.
5. Please submit all the completed Member Enrollment Forms along with your completed Group application (enclosed) and a check written out to "Delta Dental of Minnesota" for the first month's total premium to:

National Insurance Services
Service Cooperatives Dental Program
14852 Scenic Heights Road, Suite 210
Eden Prairie, MN 55344

Upon receipt of your initial application & enrollment material, we will set up your group benefits and mail back your Welcome Packet with the Group Administrator Manual, Member ID cards, Summary Plan Descriptions, etc. This process takes approximately 10-15 business days.

If you or your broker has any questions, please call National Insurance Services at 1-800-627-3660.

Sincerely,

Delta Dental of Minnesota & National Insurance Services

Corporate Headquarters

Delta Dental of Minnesota
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415-1163

Telephone: 612-224-3300
Toll-free: 1-877-268-3384

DELTA DENTAL OF MINNESOTA

Master Dental Application
Minnesota Service Cooperatives

PART A – COMPANY INFORMATION

Legal Company Name: _____

Address: _____ Phone: _____

_____ County: _____

City : _____ State: _____ Zip Code: _____

Plan Effective Date: _____

Contract Location:

First Name: _____

Last Name: _____

Business Title: _____

Business Phone: _____

Business Fax: _____

Email Address

Billing Contact Information: (If different than Contact Information)

First Name: _____

Last Name: _____

Business Title: _____

Business Phone: _____

Business Fax: _____

Email Address _____

Minnesota Service Cooperative:

- ☐ Lakes Country Service Cooperative
- ☐ North East Service Cooperative
- ☐ Northwest Service Cooperative
- ☐ Resource Training & Solutions
- ☐ South Central Service Cooperative
- ☐ Southeast Service Cooperative
- ☐ SW/WC Service Cooperative

PART B – PLAN DESIGN

☐ Voluntary

☐ Contributory Amount of Contribution _____

☐ Orthodontics $ 1,000 LTM to age 19 (Plan D Only, Minimum 10 enrolled employees)

- ☐ Plan A
- ☐ Plan B
- ☐ Plan C
- ☐ Plan D

PART C – FUNDING TYPE

☐ RISK: The first month's premium check must accompany this completed Master Dental Contract Application. Future premium payments are due on the first of each premium month.

PART D – PAYMENT METHOD

- ☐ Check
- ☐ ACH

DELTA DENTAL OF MINNESOTA

PART E – AGENT OF RECORD (if applicable)

Agency Name: _____ Broker Name: _____
Address: _____ Phone: _____
_____ County: _____
City _____ State: _____ Zip Code: _____

_____
TAX ID Number (TIN)
Note: Commissions will be paid to this TIN

_____ _____
Broker Signature Insurance Producer License ID Number

PART F - INSTRUCITONS

1. Complete Master Dental Contract Application.
2. Have each employee complete and sign a Membership Enrollment Form
3. Send this completed application, completed Membership Enrollment Forms, and the initial remittance to the following address:
   National Insurance Services, 14852 Scenic Heights Road, Suite 210, Eden Prairie, MN 55344

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are, in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than five.

Delta Dental will send a contract upon acceptance of the application and final approval of the Dental Benefits Plan Summary. The contract will indicate the effective date of coverage. The contract is effective only after Delta Dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental.

SIGNATURE BOX

Signature of Authorized Company Official Title Date

Group Administrator/Future Correspondence Contact (please print) Title

Phone Number Fax Number Email Address

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Delta Dental of Minnesota

Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last		First			Middle Initial		**Social Security Number** / /
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address					Home Phone Number ( )		Work Phone Number ( )
	City			State		Zip Code		

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who is Being Enrolled – Check One Box Only *If waiving coverage for employee and/or eligible family members, complete Part B & D.		**Plan Design Type – Check One Box Only**
☐ Employee only*	☐ Employee + 1	☐ Option 1
☐ Family	☐ No Coverage*	☐ Option 2

PART C – DEPENDENT INFORMATION

Relationship To Employee	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Employee's)	**Gender**		**Date of Birth** Month/Day/Year	**Unmarried?**	
Spouse		M	F	/ /		
Dependent Child		M	F	/ /	Y	N
Dependent Child		M	F	/ /	Y	N
Dependent Child		M	F	/ /	Y	N
Dependent Child		M	F	/ /	Y	N

PART D – OTHER INSURANCE COVERAGE

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: _____ Policy/Identification No.:_____

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: **Date:**

PART E – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment.

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: **Date:**

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Rehire** Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began: _____/_____/_____
Date Returned to Work: _____/_____/_____

☐ **Existing Delta Dental Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _____/_____/_____
Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine
Effective Date: _____/_____/_____
Hire Date: _____/_____/_____

☐ **Open Enrollment**
Effective Date:
_____/_____/_____

☐ **Previously Waived Coverage or Loss of Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers:** ----

Group Representative's Signature: **Date:** **Phone Number:** ( )

Send Original Copy to Delta Dental Retain Copy For Your Records

Employer Instructions

- Review Parts A, B, C, D, E to assure the employee provided complete, accurate and legible information.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).

Complete Part F – Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group –** New customer to Delta Dental and submitting initial employee enrollment. Note: For a New Group enrolling a Direct Billed COBRA participant, check *Other* category. Provide reason and original date of qualifying event and correct COBRA subgroup. If information is not provided, participant will not be enrolled and billed properly.
- **Open Enrollment –** Employee is enrolling during group's open enrollment period.
- **New Hire –** Enroll newly hired employee. If probationary period applies, coverage effective date is after the probationary period.
- **Rehire** – Former employee was rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other coverage and is now eligible to enroll.
- **Other –** Use if enrollment situation is not included in another category. Provide a specific reason and event date.
- **Previously Waived Coverage –** If an employee waives coverage, they can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage.
- **Employee Status Change –** Employee's employment status changed and employee is now eligible for dental benefits.
- **Group Name –** Provide group name as listed in your contract.
- **Group and Subgroup Number –** Provide applicable numbers for individual employee.
- **Group Representative –** Sign, date, and provide your phone number.

Send Completed Forms To:

Delta Dental of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis MN 55440-0330
Fax: 651-406-5935 or 800-821-5946