FOR DDIL USE ONLY:
GROUP #:____________

Application for Group Dental/Vision Coverage

Delta Dental of Illinois is unable to accept this document with any changes, cross-outs, white-outs, etc., unless the person signing the application initials those changes. Group acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance.

The applicant must be domiciled in Illinois or have a bona fide situs in Illinois.

Groups and/or brokers/consultants are required to complete all applicable sections of this application.

Application will be considered after Delta Dental of Illinois receives:

- A completed group application form.
- A deposit check for the first month's premium for fully insured groups or the receipt of the prefund or arrangements for weekly ACH for self-funded groups.
- Completed enrollment forms. (For those waiving coverage, enrollment forms must be submitted and must indicate that coverage is waived.) Enrollment forms may not be required if another eligibility reporting method is arranged in advance.

EMPLOYER/GROUP INFORMATION

REQUESTED EFFECTIVE DATE OF COVERAGE: ______________________
(Month, Date, Year)

Employer/Group: ____
(Specify the legal name of the employer, the Taft-Hartley trust or the association applying for coverage. Name of affiliated companies to be covered must also be included below. AN EMPLOYEE/GROUP BENEFIT PLAN MAY NOT BE NAMED.)

Subsidiaries/Affiliated Companies, if applicable: ____
(Legal Name)

Contracting Address: ____
Street P.O. Box City State Zip

Phone: (______) _______-____________ Fax: (______) _______-____________

Group Administrator: ______________________________ Title: ______________________________
(Authorized Person)

Administrator Phone: (______) _______-____________ E-mail: ______________________________

Billing Contact: ______________________________ Billing Contact Phone: (______) ________-______________
(If different than above)

Billing Contact Email: ______________________________ Billing Address: ______________________________
(If different than above) (If different than above)

Eligibility Contact: ______________________________ Eligibility Contact Phone: (______) _______-______________
(If different than above)

Eligibility Contact Email: ______________________________

Nature of Business: ______________________________ Years in business: __________ SIC Code: _______________
(If manufacturing, please specify principal type of product and material used.)

Type of Ownership: ☐ Sole-Proprietorship ☐ Partnership ☐ Corporation

Employer Tax Identification Number: ______________________________ Employer Plan Number: ______________________________

BROKER/CONSULTANT INFORMATION

Broker/Consultant Name: ________________________ Agency/Firm Name: ______________________________

Address: ____
Street P.O. Box City State Zip

Phone: (______) _______-____________ Fax: (______) _______-____________ Email: ______________________________

EMPLOYER/GROUP AGREEMENT

The undersigned certifies that s/he is authorized to apply for coverage for the selected group dental/vision program on behalf of the named group (“applicant”) and to sign this application.

In making this application to Delta Dental of Illinois for the selected group, the applicant agrees and understands that this application will become part of the Contract/Administrative Services Contract executed by an authorized officer of Delta Dental of Illinois. The applicant represents that all the information contained in the application is true and correct. *Misrepresentation of submitted data contained in this application will cause the contract to be null and void*.

It is agreed that the coverage requested is subject to the approval of Delta Dental of Illinois and that no agent or representative has authority to make or modify this application for coverage. Once approved by Delta Dental of Illinois, the applicant understands that coverage will not be effective until the required premium/funding and eligibility data, in a format agreed to by the parties, have been received.

FOR FULLY INSURED CONTRACTS ONLY: The applicant further understands that the rates quoted under the selected program are based upon meeting and maintaining the eligibility requirements and should participation fall below those requirements, Delta Dental of Illinois, at its discretion, may re-rate or terminate the account.

FOR ASC/SELF INSURED CONTRACTS ONLY: The group agrees to fully underwrite the risk of the selected group dental/vision plan and accept liability for payment of benefits.

I certify that the applicant has met all requirements contained in this application.

Name: ____

Title: ______________________________ Date: _______________

Signature: ____