NEW GROUP IMPLEMENTATION SUMMARY (RISK & ASC)

1. EMPLOYER/GROUP INFORMATION

Requested Effective Date of Coverage: _____ **SIC#** _____
(Month, Date, Year)

Employer/Group: _____
(Specify the legal name, the Taft-Hartley trust, or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below. An employee/group benefit plan may not be named.)

Contracting Address: _____
Street P.O. Box City State Zip Code

Phone: (_____) _____-_____ **Fax:** (_____) _____-_____

2. PLAN SPECIFICS

Deductible & Maximum Accumulation: ☐ Contract Year ☐ Calendar Year

☐ Other _____

3. EMPLOYER CONTRIBUTIONS FOR DENTAL

$_____ or _____% of the cost of the **employee's** insurance. $_____ or _____% of the cost of the **dependents'** insurance.

Total number of eligible employees: _____ **Total number of enrollees:** _____

Total number of waivers: _____

4. EMPLOYER CONTRIBUTIONS FOR DELTAVISION®

The **employer** contributes:

_____% or $_____ of the cost of the employee's vision insurance

_____% or $_____ of the cost of one dependent's (3-tier rates) or spouse's (4-tier rates) vision insurance

_____% or $_____ of the cost of child(ren) (4-tier rates) vision insurance

_____% or $_____ of the cost of family vision insurance

Total number of eligible employees: _____ **Total number of eligible family units:** _____

Total number of waivers: _____

Are all full-time employees eligible for this plan? ☐ Yes ☐ No

If no, please specify any classes not eligible: _____

Number of eligible employees not working at the above address: _____ Please specify location(s):_____

DELTA DENTAL®

5. ELIGIBILITY INFORMATION

Eligible person means (check all that apply):

☐ A full-time employee regularly scheduled to work a minimum of _____ hours per week and is on the permanent payroll.

☐ A full-time employee enrolled in the medical plan. An employee's coverage shall terminate if s/he is no longer enrolled in the medical plan.

☐ A full-time member of the contracting union or association.

☐ Domestic partners:

☐ Same sex ☐ Opposite sex ☐ Both

Are dependents of Domestic Partners covered? ☐ Yes ☐ No

Please use the following definition: ☐ Delta Dental standard (see below) ☐ Medical (please attach)

☐ Civil Union

"Domestic Partner" means an individual of (the same and/or opposite) sex of the subscriber and for whom the subscriber has completed and signed a Declaration of Domestic Partnership. The Declaration must be acceptable to the group subscriber.

☐ Retirees:

☐ Retiree age is: _____

Are dependents of Retirees covered? ☐ Yes ☐ No

Please use the following definition: ☐ Delta Dental standard (see below) ☐ Medical (please attach)

"Retiree" means a person retired from the active service of the employer and covered under this Group Dental Plan immediately prior to retirement.

☐ Other: _____

6. DELTA DENTAL PPO℠/ DELTA DENTAL PREMIER®

New Hire Eligibility Date:

☐ Following _____ days of employment ☐ On the first of the month following _____ days of employment ☐ Date of hire

☐ Other: _____

Termination Occurs On:

☐ Date employee ceases to be eligible ☐ Last day of the calendar month in which employee ceases to be eligible

Limiting Age:

Fully Insured: The limiting age for covered unmarried dependent children is 26.

Self Funded: The limiting age for covered unmarried dependent children is _____; and _____ if a full-time student.

Dependent Children coverage is terminated on: ☐ Birthday ☐ Last day of the calendar month in which the limiting age is reached

Prior Carrier: _____

7. DELTACARE

New Hire Eligibility Date:

☐ On the first of the month following the date of employment

☐ On the first of the month following _____ days of employment

Termination is on the last day of the calendar month in which such person ceases to meet the definition of eligible person.

Prior Carrier: _____

8. DELTAVISION®

☐ Group Vision Coverage ☐ Group Voluntary Coverage

Is the eligibility the same for DeltaVision as for the dental program? ☐ Yes ☐ No If no, please specify eligibility requirements for the vision program: _____

New Hire Eligibility Date:

☐ Following _____ days of employment ☐ On the first of the month following _____ days of employment ☐ Date of hire

☐ Other: _____

Termination Occurs On:

☐ Date employee ceases to be eligible ☐ Last day of the calendar month in which employee ceases to be eligible

Limiting Age:

Fully Insured: The limiting age for covered unmarried dependent children is 26.

Self Funded: The limiting age for covered unmarried dependent children is _____; and _____ if a full-time student.

Dependent Children coverage is terminated on: ☐ Birthday ☐ Last day of the calendar month in which the limiting age is reached

Prior Carrier: _____

*Please Note: DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

9. MONTHLY BILLING DELIVERY INFORMATION

☐ E-mail/Online Billing ☐ Fax ☐ Other: _____

Summary Billing includes a summary of enrollees, prior balance, adjustments, current billed and total due by location with a grand total for all locations. If group has multiple locations, does the group require **Summary Billing**? (Fully insured groups only.) ☐ Yes ☐ No

10. MONTHLY PREMIUM RATES — Fully Insured

Binder Amount: $_____ ☐ Wire Transfer ☐ Check

Delta Dental PPO℠/ Delta Dental Premier®

Single Dental Rate	$
Single + Spouse OR Single + Dependent Dental Rate	$
Single + Child(ren) Dental Rate	$
Single + Family Dental Rate	$

☐ 1-year rate ☐ 2-year rates ☐ 3-year rates Rates guaranteed from _____ to _____.

DeltaCare

Single Dental Rate	$
Single + Spouse OR Single + Dependent Dental Rate	$
Single + Child(ren) Dental Rate	$
Single + Family Dental Rate	$

☐ 1-year rate ☐ 2-year rates ☐ 3-year rates Rates guaranteed from _____ to _____.

DeltaVision®

Single Vision Rate	$
Single + Spouse OR Single + Dependent Vision Rate	$
Single + Child(ren) Vision Rate	$
Single + Family Vision Rate	$

☐ 1-year rate ☐ 2-year rates ☐ 3-year rates Rates guaranteed from _____ to _____.

X_____

Authorized Signature **(Your signature confirms your acceptance of the rates listed above.)**

11. ADMINISTRATIVE FEE — Self Funded

The group agrees to pay Delta Dental of Illinois for *dental* monthly $_____ per employee per month for _____ months.

Prefund Amount: $_____ ☐ Wire Transfer ☐ Check **OR** Weekly Payment: ☐ ACH Debit* ☐ Wire Transfer

***If ACH Debit, please supply banking information:**

Bank Name:_____

Account Number: _____ Routing Information: _____

X_____

Authorized Signature **(Your signature confirms your acceptance of the fees listed above.)**

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