



**SMALL BUSINESS PROGRAM
GROUP DENTAL AND VISION APPLICATION**

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105
415-972-8300

APPLICANT INFORMATION

Name of Applicant:		Fed. ID/TIN:		Public Entity: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact:		Phone:			
Email:		Fax:			
Address:					
City:		State:	ZIP Code:	County:	
Industry Type:		SIC:			
Billing Address, if different:					
Billing Contact:		Phone:		Fax:	
Billing Email:					
Situs State: California	Group Type: Employer		Contract Type: Non Retention		Length of Contract: 1 year
Proposed Effective Date:					
Recipient of Electronic Documents and Notices: <input type="checkbox"/> Applicant <input type="checkbox"/> Other (provide name and email, address or fax number):					
I, the Contractholder, authorize the broker to manage eligibility on my behalf: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Dual Choice: <input type="checkbox"/> Yes <input type="checkbox"/> No					
DeltaVision: <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, additional vision information is not needed.)					
Vision Benefit Year (select one): <input checked="" type="checkbox"/> Service Year (from last date of service)			Vision Plan Type (select one): <input checked="" type="checkbox"/> Choice Plan		
Name of prior dental carrier:			Name of prior vision carrier:		

DELTA DENTAL PPO™ BENEFIT DESIGNS – Underwritten by Delta Dental of California

	CORE	ADVANTAGE	DELUXE
Select a Dental PPO plan	PPO: <input type="checkbox"/> Core 100 <input type="checkbox"/> Core 201	PPO Plus Premier™: <input type="checkbox"/> Advantage 100 <input type="checkbox"/> Advantage 200 <input type="checkbox"/> Advantage 300 PPO: <input type="checkbox"/> Advantage 400	PPO Plus Premier: <input type="checkbox"/> Deluxe 100 <input type="checkbox"/> Deluxe 200 PPO: <input type="checkbox"/> Deluxe 300
Calendar Year Maximum (Per Enrollee)	<input type="checkbox"/> \$750 (Core 201 only) <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 (Advantage 200 and 400 only)	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000
Orthodontic Services (Optional)		<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Child (Advantage 200 and 400 only)	<input type="checkbox"/> Child Only <input type="checkbox"/> Adult & Child
Orthodontic Lifetime Maximum (Per Enrollee)		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<input type="checkbox"/> \$1,500
D&P Maximum Waiver®		<input type="checkbox"/> Yes	

DELTACARE® USA BENEFIT DESIGNS – Underwritten by Delta Dental of California

	CORE	ADVANTAGE	DELUXE
Select a DeltaCare USA plan	<input type="checkbox"/> 17B	<input type="checkbox"/> 15B	<input type="checkbox"/> 11A

DELTA DENTAL'S DUAL CHOICE BENEFIT DESIGNS

☐ Dual Choice 1 - Choose any one Delta Dental PPO plan and any one DeltaCare USA plan from above

<input type="checkbox"/> Dual Choice 2	D&P Maximum Waiver <input type="checkbox"/> Yes	Orthodontic Services (Optional) <input type="checkbox"/> Child Only	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
<input type="checkbox"/> Dual Choice 3	D&P Maximum Waiver <input type="checkbox"/> Yes (low and high plans) <input type="checkbox"/> Yes (high plan only)	Orthodontic Services (Optional) <input type="checkbox"/> Child only (low and high plans) <input type="checkbox"/> Child Only (high plan only)	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$1,000 low/\$1,500 high <input type="checkbox"/> \$1,500 low/\$2,500 high
<input type="checkbox"/> Dual Choice 4	D&P Maximum Waiver <input type="checkbox"/> Yes (high plan only)	Orthodontic Services (Optional) <input type="checkbox"/> Child Only (high plan only)	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$750 low/\$1,500 high <input type="checkbox"/> \$1,000 low/\$2,000 high
<input type="checkbox"/> Core/Buy-Up	Fee Basis (select one) <input type="checkbox"/> PPO <input type="checkbox"/> PPO Plus Premier D&P Maximum Waiver <input type="checkbox"/> Yes (buy-up plan only)	Orthodontic Services (Optional) <input type="checkbox"/> Child Only (buy-up plan only)	Calendar Year Maximum (Per Enrollee) <input type="checkbox"/> \$750 core/\$1,500 buy-up <input type="checkbox"/> \$1,000 core/\$2,000 buy-up

DELTAVISION® BENEFIT DESIGNS – Underwritten by Delta Dental of California

Select a Vision plan	<input type="checkbox"/> DeltaVision Core 10/25/150 (12/12/24) <input type="checkbox"/> DeltaVision Value 10/25/130 (12/12/24)	<input type="checkbox"/> DeltaVision Advantage 10/25/150 (12/12/12)	<input type="checkbox"/> DeltaVision Easy Options 10/25/150+Easy Options (12/12/12) <input type="checkbox"/> DeltaVision Deluxe 10/10/200 (12/12/12)
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CONTRIBUTION AND PARTICIPATION**PPO Employer Contribution and Participation Requirement (check one):**

☐ 100% All eligible employees ☐ 75%-99.9% 75% of eligible employees ☐ 50%-74.9% 50% of eligible employees ☐ 0%-49.9% (Voluntary Plan Only)

For groups with 5 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 5 primary enrollees. For groups with 2-4 eligible enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.

DeltaCare USA Employer Contribution Requirement (check one):

☐ At least 75% for employees and dependents ☐ At least 75% for employees ☐ Less than 75% for employees

Enrollment may not be less than 2 primary enrollees.

PPO Core/Buy-Up Employer Contribution* and Participation Requirement (check one):

☐ 100% All eligible employees ☐ 75%-99.9% 75% of eligible employees ☐ 50%-74.9% 50% of eligible employees

Enrollment, in both the Core and Buy-Up options, may not be less than the greater of the percentage listed above or five primary enrollees.

* Employer contribution is based solely on the Core rates.

DeltaVision Employer Contribution and Participation Requirement (check one):

☐ 100% All eligible employees ☐ 75%-99.9% 75% of eligible employees ☐ 50%-74.9% 50% of eligible employees ☐ 0%-49.9% (Voluntary Plan Only)

For groups with 2 or more eligible enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

Dental Rates and Enrollment				Second Plan if Dual Choice is Selected			
	Monthly Rates	#Primary Enrollees	Total		Monthly Rates	#Primary Enrollees	Total
3 Tier							
EE Only	\$	x	= \$	EE Only	\$	x	= \$
EE+1	\$	x	= \$	EE+1	\$	x	= \$
EE+2 or more	\$	x	= \$	EE+2 or more	\$	x	= \$
4 Tier							
EE Only	\$	x	= \$	EE Only	\$	x	= \$
EE+Spouse	\$	x	= \$	EE+Spouse	\$	x	= \$
EE+Child(ren)	\$	x	= \$	EE+Child(ren)	\$	x	= \$
EE+Family	\$	x	= \$	EE+Family	\$	x	= \$
TOTAL			\$	TOTAL			\$
DeltaVision Rates and Enrollment							
	Monthly Rates	#Primary Enrollees	Total				
3 Tier							
EE Only	\$	x	= \$				
EE+1	\$	x	= \$				
EE+2 or more	\$	x	= \$				
4 Tier							
EE Only	\$	x	= \$				
EE+Spouse	\$	x	= \$				
EE+Child(ren)	\$	x	= \$				
EE+Family	\$	x	= \$				
TOTAL			\$				
ELIGIBILITY INFORMATION							
Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):							
# of Eligible Employees:							
PPO*			DeltaCare*		Dual Choice PPO		
# of Enrolled Employees:			# of Enrolled Employees:		# of Enrolled Employees (Low/Core/PPO Plus Premier): # of Enrolled Employees (High/Buy-Up/PPO):		
# of DeltaVision Enrolled Employees:							
Eligible Individuals (check applicable boxes): <input checked="" type="checkbox"/> Eligible Employees <input type="checkbox"/> Retired Employees							
Eligible Dependents (check applicable boxes): <input checked="" type="checkbox"/> Spouse <input checked="" type="checkbox"/> Children <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Others							
Eligible Requirement (check one): <input type="checkbox"/> Date of hire <input type="checkbox"/> First of the month following date of hire <input type="checkbox"/> First of the month following ____ days of employment							

* If electing Dual Choice 1 populate both PPO and DeltaCare enrolled employee fields.

Application is herewith made for a dental and/or vision service contract from Delta Dental of California (Delta Dental). It is understood that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the plan. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to and accepted by Delta Dental or its designated administrator(s), 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered as an inducement for issuance of a dental and/or vision service contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. To that end, the signer of the Application declares that they have read the statements and responses above and that to the best of their knowledge the responses are true. No waiver or modification of the Application will be accepted unless in writing and signed by an authorized officer of Applicant.

This plan will become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility will be submitted to Delta Dental's designated administrator by the 25th of the month prior to the coverage month.***

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant must provide Delta Dental or its designated administrator with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental service contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental plan as described in the group dental service contract or as permitted or required by law. Delta Dental and Applicant must comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta Dental.

Executed this _____ day of _____, 20____, for the Applicant at: _____			
(City and State)			
By: _____		Signature: _____	
(Print Name and Title)			
Delta Dental Authorized Signature: _____			
(Michael G. Hankinson, Esq., EVP, Chief Legal Officer)			
BROKER/AGENT INFORMATION			
Broker/Agent Name:		State License:	
National Producer Number:			
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commission Mailing Address:	City:	State:	Zip Code:
Broker/Agent Name:		State License:	
Broker/Agent Signature:			Date:
GENERAL AGENT INFORMATION			
General Agent Name:		State License:	
National Producer Number:			
Contact Email:	Phone:	Fax:	
Company Name:	SSN/TIN:	Is Company Inc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commission Mailing Address:	City:	State:	Zip Code:
Commission(s): Dental: _____ Vision: _____		Payable to: _____	
General Agent Signature:			Date:

ELECTRONIC DELIVERY OF DOCUMENTS TERMS AND CONDITIONS

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your Dental and/or Vision contract-related documents made available to you electronically. If you choose to have your contract-related documents made available to you electronically, the terms & conditions below apply.

1. **Communication Methods:** All communications that we provide to you in electronic form will be provided either (1) by accessing the Delta Dental or Delta Dental's designated administrator website with your user name and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received, unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic documents disclosure and any other document that is important to you.
2. **Types of Documents that Will Be Electronically Communicated:** Documents available electronically include, but are not limited to: your contract, the Evidence of Coverage (Certificate/EOC) for your enrollees and your notifications.
3. **How to Withdraw Consent:** You may withdraw your consent to transact business electronically by contacting Delta Dental's designated administrator. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic Communications. A withdrawal of your consent to transact business electronically will be effective only after we have had a reasonable period of time to process your request.
4. **How to Update Your Records:** It is your responsibility to provide us with true, accurate and complete email address, and to maintain and update promptly any changes in this information. You can update your information by contacting Delta Dental's designated administrator.
5. **Hardware and Software Requirements:** In order to access, view, sign and retain electronic documents that we make available to you, you must:
 - Have a device that will connect to the Internet, access to an email account and access to an internet browser.
 - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
 - Be able to view the disclosures on your device.
 - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.

☐ **Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents provided electronically.**

Delta Dental Administrator's Use ONLY

Application accepted on: _____

Delta Dental PPO Group #: _____

TPA Employer #: _____

DeltaCare USA Group #: _____

TPA Employer #: _____

Delta Dental Secondary PPO Group #: _____

TPA Employer #: _____

DeltaVision Group #: _____

TPA Employer #: _____