Delta Dental of Nebraska
Atrium Executive Square
11235 Davenport Street, Suite 105
Omaha, NE 68154
(402) 397-4878 or 1-800-736-0710

Master Dental Contract Application
Pooled Programs

PART A - COMPANY INFORMATION

Legal Company Name _____

Address _____ Phone ( ) _____

_____

City _____ State _____ Zip Code _____

Plan Effective Date: _____

Eligible employees are all employees working _____ hours or more per week.

Eligibility probationary period for new employees: First of month following: _____ Other: _____

Type of Coverage: ☐ Employee Only ☐ Employee and Dependents

Does your company currently have a dental plan? ☐ No ☐ Yes (Name of carrier) _____

(Attach copy of most recent billing statement) Length of coverage: _____

PART B - PARTICIPATION

Total number of eligible employees _____ ***(A minimum of five (5) employees must enroll.)***

☐ 5-14 Eligible Employees – 100% of all employees not covered elsewhere under a dental contract must be enrolled; 75% of dependents not covered elsewhere under a dental contract must enroll if dependent coverage is selected.

☐ 15-99 Eligible Employees – 100% of all employees not covered elsewhere under a dental contract must be enrolled; 75% of dependents not covered elsewhere must enroll if dependent coverage is selected.

☐ 15-99 Eligible Employees – 80% of all employees not covered elsewhere under a dental contract must be enrolled; 80% of dependents not covered elsewhere must enroll if dependent coverage is selected.

☐ 100-199 Eligible Employees **(Millennium Choice Only)** – 100% of all employees not covered elsewhere under a dental contract must be enrolled; 75% of dependents not covered elsewhere under a dental contract must enroll if dependent coverage is selected.

☐ 100-199 Eligible Employees **(Millennium Choice Only)** – 80% of all employees not covered elsewhere under a dental contract must be enrolled; 80% of dependents not covered elsewhere under a dental contract must enroll if dependent coverage is selected.

☐ **Discover and Dental Flex** groups are required to have a minimum of 5 eligible employees enrolled.

☐ **MEDICAL LOCK** (Must include a copy of most recent medical billing statement.)

PART C – DENTAL PRODUCT (choose one):

☐ **Comprehensive Standard** **Deductible**: ☐ $25/$75 ☐ $50/$150 **Rates Sold:** Single $_____ Family $_____

☐ **Comprehensive Enhanced** **Deductible:** ☐ $25/$75 ☐ $50/$150 **Rates Sold:** Single $_____ Family $_____

☐ **Basic** **Rates Sold**: Single $_____ Family $_____

☐ **Millennium Choice** (Choose one maximum and one deductible)

Deductible: ☐ $25/$75 or ☐ $50/$150 ☐ $100 Lifetime Deductible **Annual Maximum:** ☐ $1000 or ☐ $1500

Rates Sold: Single $_____ EE+Sp $_____ EE+Child(ren) $_____ Family $_____

PART D - ORTHODONTICS

Does the prior dental plan have orthodontic coverage? ☐ No ☐ Yes | ☐ $1,000 Lifetime Max | ☐ $1,500 Lifetime Max

☐ Add the orthodontics option to the above elected program (for groups with 10 or more enrolled employees).

PART E – VOLUNTARY

☐ Discover Option I	$0 Deductible	$500 Annual Maximum	☐ Dental Flex - Requires completion of a Dental Flex Enrollment Form
☐ Discover Option II	$25 Deductible	$500 Annual Maximum	☐ $50/$150 Deductible ☐ $100 Lifetime Deductible
☐ Discover Option III	$25 Deductible	$750 Annual Maximum	
☐ Discover Option IV	$25 Deductible	$1,000 Annual Maximum	****DENTAL FLEX ORTHODONTICS:** ☐ No ☐ Yes
****DISCOVER ORTHODONTICS**: ☐ No ☐ Yes (No waiting periods apply)			NOTE: If adding orthodontics and orthodontics were not covered under your current/previous dental plan, there will be a 12-month waiting period for orthodontic benefits under the Dental Flex plan.

****PLEASE NOTE:** Orthodontics is available for groups with 10 or more enrolled employees and is limited to dependent children age 8 through age 18.

Employer Premium Contribution 50% or greater? ☐ No ☐ Yes

*3-Tier rating is the only option for Dental Flex; Discover 3-tier rating is available for groups with 100+ enrolled employees.

Rate Options	**Rates Sold**
☐ Two Tier ☐ Three Tier*	Single $_____ Single+1* $_____ Family $_____

AGENT OF RECORD (if any) ***Completion of all fields required***

Name _____ Agency _____

Address _____ Phone ( ) _____

City _____ State _____ Zip Code _____

_____ _____

Agent Signature / NE Insurance Agent License ID Number Tax ID Number

Note: Commissions will be paid to this TIN.

PREMIUM REMITTANCE

The first month's premium must accompany the application. Thereafter, the monthly premium payment and the corresponding statement or invoice must be received by the first of each month.

1. Complete application. Retain green copy for your files.
2. Have each employee complete and sign a Membership Enrollment Form.
3. Send the original application, completed Membership Enrollment Forms and the first month of premium to above address on top right of page one – **For questions call (402) 397-4878 or (800) 736-0710.**
4. Payment Options:

Preferred: ☐ **ACH** **Please note: .25% premium discount for ACH** (Include ACH Authorization Form and voided check)

☐ CHECK ☐ WIRE

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 return a contract upon acceptance of the application. 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