DELTA DENTAL

Delta Dental of Nebraska

Employer Application
Delta Dental Small Business Clients

PART A – Client Information

Plan Effective Date: _____

Legal Company Name: _____

Physical Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip Code: _____

Mailing Address ☐ Same as client physical location: _____

City: _____ State: _____ Zip Code: _____

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

(Include a copy of most recent billing statement and benefit summary) Prior Plan Start Date: _____

Total Number of Eligible Employees: _____

Estimated enrolled Subscriber count: _____

Client Contact Information

First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ [General] ☐ [Renewal] ☐ [Billing] ☐ [Mailing] ☐ [Materials] ☐ [Overage Dependent]

Telephone: _____ Ext: _____ Cell: _____

Email Address: _____

☐ Same as Client Physical Location

Mailing Address _____

City: _____ State: _____ Zip Code: _____

Additional Client Contact Information (if applicable)

First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ [General] ☐ [Renewal] ☐ [Billing] ☐ [Mailing] ☐ [Materials] ☐ [Overage Dependent]

Telephone: _____ Ext: _____ Cell: _____

Email Address: _____

☐ Same as Client Physical Location

Mailing Address _____

City: _____ State: _____ Zip Code: _____

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Client – Benefit Manager Toolkit Registration

Update your group's eligibility on-line, in real time, using our web-based tool, Benefit Manager Toolkit (BMT). With BMT you can enroll a new member, update existing members, view eligibility and your benefits, and print dentist directories. In addition, **your monthly invoice and other billing details are provided to you exclusively through BMT.**

Select a Client Administrator within your company and complete the information below. This administrator will be able to create and maintain your accounts, enabling immediate access for your BMT users. Delta Dental will send your administrator an email with registration information and additional instructions. **BMT Administrator must be an employee of the client.**

Administrator Name: _____ Title: _____

Email: _____ Phone Number: _____

PART B – Dental Program Options (choose only one)

Available for groups with 2 - 100 eligible employees, minimum of 2 employees must enroll.
*Waiting are periods applicable, unless otherwise indicated. Waiting periods may also be waived with twelve (12) months of prior comparable coverage for all **initial enrollment** on plan effective date. This application does not guarantee coverage.*

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Solutions 1000 (with or without child orthodontic coverage):**

☐ Yes, we accept child orthodontic coverage
☐ No, we decline child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Solutions 1500:**

☐ Yes, we accept child orthodontic coverage
☐ No, we decline child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Solutions 2000 (with or without child orthodontic coverage):**

☐ Yes, we accept child orthodontic coverage
☐ No, we decline child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Delta Dental PPO Plus Premier™ - Delta Dental Flex:**

Annual Plan Maximum Options *Please check (✓) one below:*

☐ $1,000 per person per year
☐ $1,500 per person per year

☐ Yes, we accept child orthodontic coverage
☐ No, we decline child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

☐ **Delta Dental PPO Plus Premier™ - Pathfinder 2 - 6:** *Please check (✓) one below:*

☐ Pathfinder 2
☐ Pathfinder 3
☐ Pathfinder 4
☐ Pathfinder 5
☐ Pathfinder 6 - Plan waiting periods do not apply; with child orthodontic coverage

Please confirm sold plan rates

Employee _____
Employee + Spouse _____
Employee + Child(ren) _____
Family _____

Continued

PART C – Broker of Record - Completion of all fields is required

Broker Name: _____ **Agency:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **E-mail Address:** _____

_____ _____

Broker Signature / Insurance Broker License ID Number **Tax ID Number**

Note: Commissions will be paid to this TIN

AGENT/AGENCY - BENEFIT MANGER TOOLKIT AUTHORIZATION

With the Benefit Manager Toolkit (BMT), the Broker of Record can update and view the client's eligibility and access the client's billing details. The Broker/Agency will work with their Agency's BMT Administrator, who will add the appropriate user permissions to the Broker's access.

PART D – Premium Remittance and Submission

The first month's premium payment must be received in order for Delta Dental to pay claims for your members.

Please submit your first month's premium with your application:

1. Select Payment Option: ☐ **ACH** ☐ **Check** **Make payable to: Delta Dental of Nebraska and mail payments to**: Delta Dental of Nebraska, NW 5767, PO Box 1450, Minneapolis, MN 55485-5767
2. Complete the Employer Application. Retain a copy for your files.
3. Have each employee complete and sign an Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Client Administrator.
4. Send the Employer Application, completed Enrollment Forms or approved Enrollment spreadsheet, and corresponding Dental Proposal to: DeltaDentalConnect@DeltaDentalNE.org

For questions call 1-866-280-8367 or DeltaDentalConnect@DeltaDentalNE.org

Client Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by the Company (Company as named in Part A above) and agree to provide substantiating evidence when requested.

If Delta Dental accepts this application, Delta Dental will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental. 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 two.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

_____ _____ _____

Signature of Authorized Company Official Title Date

_____ _____

Client Administrator/Future Correspondence Contact (please print) Title

_____ _____

Phone Number Email Address