Thank you for choosing Delta Dental. Please take a moment to complete this form. This form along with your enrollment data and sold proposal will be used to set up your client with Delta Dental.

If you have any questions regarding this form or any of Delta Dental's programs, please feel free to contact your Delta Dental representative.

Instructions:

1. Complete Client Information Form
2. Have each employee complete an Enrollment Form, or work with your Delta Dental Connect Representative to complete an Enrollment Spreadsheet, or an 834 Electronic setup
3. Send this completed application, completed Enrollment Forms, as well as the completed ACH form, voided check, and the initial remittance (if applicable) to the following address: **Delta Dental of Nebraska, 500 Washington Avenue South, Suite 2060, Minneapolis MN 55415**

CLIENT INFORMATION FORM

Coverage or administration for your group will not start until you receive approval in writing from Delta Dental.

Client ID Number *(for Delta Dental use only)*: _____

Client Name: _____

Plan: Nebraska

Client Tax Identification/EIN #: _____

Eligible Employees: _____

Effective Date: _____ Contract Length: ☒ 1 year

Physical Location: _____

City: _____ State: _____ ZIP Code: _____ County: _____

Do you need a plan that complies with the ACA's Essential Health Benefits? ☐ Yes ☐ No

If yes, what is the date of your medical plan renewal? _____

CLIENT CONTACT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials ☐ Over-age Dependent

Telephone: (_____) _____ Ext: _____ Cell: (_____) _____

Fax: (_____) _____ Email Address: _____

☐ Same as Client Physical Location

Address: _____

City: _____ State: _____ ZIP Code: _____

OTHER CLIENT CONTACT INFORMATION (if the billing contact is different from above)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name:_____ Last Name: _____

Title:_____

Contact Type: ☐ Billing

Telephone: (_____)_____ Ext:_____ Cell: (_____)_____

Fax: (_____)_____ Email Address: _____

☐ Same as Client Physical Location

Address:_____

City:_____ State:_____ ZIP Code: _____

CLIENT - BENEFIT MANAGER TOOLKIT REGISTRATION

Update your group's eligibility online, 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.

Administrator Name:_____ Title: _____

Email:_____ Phone Number:_____

Note: BMT Administrator must be an employee of the client.

AGENT/AGENCY - BENEFIT MANAGER TOOLKIT AUTHORIZATION

I **authorize** that the assigned Agent/Agency (below) requires access to the benefit manager toolkit as indicated.

Please indicate the type of access for the assigned Agent/Agency.

Type of Access:

☐ UPDATE AND VIEW ELIGIBILITY
☐ VIEW ELIGIBILITY ONLY
☐ BILLING DETAILS

Note: The Agent/Agency is responsible for the registration and creation of their BMT account(s).

Authorized Signature:_____ Date:_____

ADDITIONAL INFORMATION

Prior Carrier? ☐ Yes ☐ No *(if yes, please provide a current copy of invoice and benefit summary from prior carrier)*

Name of Prior Carrier:_____

FOR AGENTS ONLY

Agent Name: _____

Agency Name: _____

Checks to: ☐ Agency ☐ Agent

New agent/agency? ☐ Yes ☐ No If yes, please complete the Agent Appointment Application online
http://www.deltadentalne.org/appointment/#/application/get-started

TIN: _____

NPN#: _____ Insurance Producer License ID #: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: (_____) _____ Fax Number: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

Another Agent? ☐ Yes

If yes: NPN#: _____ Agent Name: _____

Commission is paid at 10%

*If commission is split please provide percentages:

Agent_____%_____

Agent_____%_____

Start Date: _____

Contact Agent Name (if different than above): _____

Telephone: (_____)_____ Fax Number: (_____)_____

Cell Phone:(_____)_____ Email Address: _____

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Delta Dental of Nebraska in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Delta Dental. This requirement is a condition to eligibility for receiving compensation under Delta Dental's agency/agent compensation program as described in Delta Dental's Agency/Agent Agreement. Delta Dental will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this form I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Delta Dental related to the client's purchase of a Delta Dental benefit plan.

Agent's Signature: _____ Date: _____

BILLING CONFIGURATION

Bill Type (How would you like to receive your bill?): ☐ Mail ☐ Email Notification Only (Benefit Manager Toolkit)

Payment Method: ☐ Check ☐ ACH (DDNE initiated ACH)

SUBCLIENT INFORMATION

- The account structure is used for reporting and accounting purposes.
- Delta Dental will assign a client number.
- Subclient names/numbers will be assigned unless directed otherwise.
- If you prefer to modify, please note that subclient numbers consist of four digit numeric or alpha characters.

Please review the Dental Account Structure below carefully.

CLIENT NUMBER	SUBCLIENT NUMBER	SUBCLIENT NAME

BILL CONSOLIDATION

All subclients will be billed [separately] [collectively] unless directed otherwise.

Please indicate below any bill consolidation requirements:

1. _____

2. _____

3. _____

ELIGIBILITY AGE LIMITS FOR DEPENDENT CHILD(REN)

Age dependent child(ren) coverage ends: 26

When does dependent child(ren) coverage end? ☒ End of Month

COB PROCESSING INFORMATION

Payment Option Type: ☒ Standard

Support Internal COB (Spouses with the same employer can cover each other): Yes ☐ No ☒

Support External COB (Spouses with different employers can cover each other): Yes ☒ No ☐

SUBSCRIBER DEFINITION (by subclient, if applicable)

Example: *All full-time employees of the Contractor working at least 30 hours per week.*

NEW EMPLOYEE/MEMBER PROBATION PERIOD (WAITING PERIOD)

Example: *On the first day of the month following 90 days of employment*

☐ 1st of the Month Following_____Days

☐ Hire Date

☐ Employer Determined: _____

TERMINATION LANGUAGE (when should coverage end)

☐ Term at End of Month

DOMESTIC PARTNER COVERAGE

Domestic Partner Covered? Yes ☐ No ☐

EMPLOYEE CONTRIBUTION

*Please confirm the percentage that the **employer** contributes for employees and dependents:*

_____% **Employer** Contribution for Employee

_____% **Employer** Contribution for Dependents

_____Other Contribution

ENROLLMENT

Open Enrollment: ☐ Annual / All (Subscribers & Dependents) ☐ Bi-Annual *(Discover Only)*

If yes, Open Enrollment Dates: _____

Initial Enrollment Format:

- ☐ Enrollment Forms (Less than 100 lives)
- ☐ Delta Dental's one-time load layout (Excel File)
- ☐ EDI – Electronic File Feed (allow at least 8 weeks for setup) Vendor Name:_____

Anticipated Date of Receipt:_____ **Who Will be Sending:**_____

Ongoing Enrollment (used to make adds, changes, and terminations going forward):

- ☐ Enrollment Forms (Less than 100 lives)
- ☐ Online Dental Portal (Benefit Manager Toolkit)
- ☐ EDI – Electronic File Feed

Benefit Dates:

Coverage period for annual deductibles and maximums:

☒ Calendar Year (January through December)

AGREEMENT

The undersigned client hereby adopts and subscribes to the terms and provisions in this form and certifies to the best of his/her knowledge and belief, all the responses are true, correct and complete. I verify that the eligible employees are in fact employed by my company 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 five.

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 the Company executes the contract.

In addition to the commissions and/or fees identified specifically for your plan, the Agency/Agent may qualify for additional compensation payments from Delta Dental related to your purchase of a Delta Dental benefit plan. This additional compensation is not charged to your plan. The Agent/Agency of Record has full authority to act on the client's behalf in all matters concerning the client's dental benefits administration, including but not limited to contractual matters and changes to the client's contract.

Misrepresentation or fraud will cause your contract to be null and void from the start and may be in violation of state law.

Payment of the first month's rate for the proposed Delta Dental program(s) and a copy of the proposal must accompany this form.

Signature of Client's Authorized Official:_____ Date:_____

Printed Name: _____

Title: _____

Signature of Agent or Delta Dental Representative:_____ Date: _____

Amount Received: $_____ Check Number: _____