FOR DDIL USE ONLY:
GROUP #:_____

Application for Group Dental/Vision Coverage

POOLED PROGRAM

Delta Dental of Illinois is unable to accept this document with any changes, cross-outs, white-outs, etc., unless the person signing the application initials those changes. Group acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance.

The applicant must be domiciled in Illinois or have a bona fide situs in Illinois. The policy and premium statements will only be issued to this Illinois address.

Groups and/or brokers/consultants are required to complete all applicable sections of this application.

Application will be considered after Delta Dental of Illinois receives:

- A completed group application form.
- A deposit check for the first month's premium.
- A copy of the proposal outlining the selected benefits or a group benefit form.
- Completed enrollment forms. (For those waiving coverage, enrollment forms must be submitted and must indicate that coverage is waived.) Enrollment forms may not be required if another eligibility reporting method is arranged in advance.

For groups with 2 to 4 benefit eligible employees, the applicant agrees to enroll a minimum of 2 employees. If enrollment falls below this requirement after the applicant's Effective Date, Delta Dental reserves the right to modify the covered Dental Benefits, change the premium rates or terminate the applicant's group dental/vision plan.

For groups with 5 or more benefit eligible employees, the applicant agrees to maintain a minimum enrollment of 50% of all eligible employees. If enrollment falls below this requirement after the applicant's Effective Date, Delta Dental reserves the right to modify the covered Dental Benefits, change the premium rates or terminate the applicant's group dental/vision plan.

1. EMPLOYER/GROUP INFORMATION

REQUESTED EFFECTIVE DATE OF COVERAGE: _____
(Month, Date, Year)

Employer/Group: _____
(Specify the legal name of the employer, 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).

Subsidiaries/Affiliated Companies, if applicable: _____
(Legal Name)

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

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

Group Administrator: _____ Title: _____
(Authorized Person)

Administrator Phone: (_____) _____-_____ E-mail: _____

Billing Contact: _____ Billing Contact Phone: (_____) _____-_____
(If different than above)

Billing Contact E-mail: _____ Billing Address: _____
(If different than above) (If different than above)

Eligibility Contact: _____ Eligibility Contact Phone: (_____) _____-_____
(If different than above)

Eligibility Contact E-mail: _____

Nature of Business: _____ Years in business: _____ SIC Code: _____
(If manufacturing, please specify principal type of product and material used.)

Type of Ownership: ☐ Sole-Proprietorship ☐ Partnership ☐ Corporation ☐ LLC

Employer Tax Identification Number: _____

2. CURRENT DENTAL/HEALTH CARRIER INFORMATION

Current dental carrier: _____ Address: _____
(Please attach a copy of the following from your current carrier: 1) Current monthly bill, 2) Description of current coverage (i.e. brochures, certificates, etc.)

3. PLAN SPECIFICS

Benefits Accumulation: ☐ Contract Year ☐ Calendar Year

Essential Health Benefit: ☐ Yes ☐ No

4. EMPLOYER CONTRIBUTIONS FOR DENTAL

The employer contributes:

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

$_____ or _____% of the cost of one or more dependents' insurance.

5. 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 family vision insurance

DELTA DENTAL®

6. ELIGIBILITY INFORMATION

Eligible person means:
A full-time employee of the contracting employer who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the employer.

Termination Occurs On:

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

Limiting Age:
The limiting age for covered unmarried dependent children is 26.
Dependent Children coverage is terminated on: ☐ Birthday ☐ Last day of the calendar month in which the limiting age is reached

Total number of eligible _____ Total number of enrollees _____ Total number of waivers _____

Delta Dental PPO℠/Delta Dental Premier®

New hire eligibility date:

☐ On the date of employment
☐ Following _____ days of employment.
☐ On the first of the month following _____ days of employment.
- ☐ 0 days
- ☐ 30 days
- ☐ 60 days
- ☐ 90 days

DeltaCare® (if applicable)

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.

Delta Dental of Illinois plan option chosen (please attach copy of quote)

7. DELTAVISION®

☐ Group Non-Voluntary Vision Coverage ☐ Group Voluntary Vision 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: _____

Termination Occurs On:

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

Limiting Age:
The limiting age for covered unmarried dependent children is 26.
Dependent Children coverage is terminated on: ☐ Birthday ☐ Last day of the calendar month in which the limiting age is reached

Total number of eligible _____ Total number of enrollees _____ Total number of waivers _____

*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.

8. 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

DELTA DENTAL®

9. MONTHLY PREMIUM RATES

Delta Dental PPO℠/ Delta Dental Premier®	
Employee Rate	$
Employee + 1 Rate	$
Family Rate	$

DeltaCare	
Employee Rate	$
Employee + 1 Rate	$
Family Rate	$

DeltaVision®	
Employee Rate	$
Employee + 1 Rate	$
Family Rate	$

10. EMPLOYER/GROUP AGREEMENT

The undersigned certifies that s/he is authorized to apply for coverage for the selected group dental/vision program on behalf of the named group ("applicant") and to sign this application.

In making this application to Delta Dental of Illinois for the selected group dental/vision coverage, the applicant agrees and understands that this application will become part of the Contract executed by an authorized officer of Delta Dental of Illinois. The applicant represents that all the information contained in the application is true and correct. *Misrepresentation of submitted data contained in this application will cause the contract to be null and void*.

It is agreed that the coverage requested is subject to the approval of Delta Dental of Illinois and that no agent or representative has authority to make or modify this application for coverage. Once approved by Delta Dental of Illinois, the applicant understands that coverage will not be effective until the required premium/funding and eligibility data, in a format agreed to by the parties, have been received.

The applicant further understands that the rates quoted under the selected program are based upon meeting and maintaining the eligibility requirements and should participation fall below those requirements, Delta Dental of Illinois, at its discretion, may re-rate or terminate the account.

I certify that the applicant has met all requirements contained in this application.

Name: _____

Title: _____ Date: _____

Signature: _____

11. BROKER/CONSULTANT INFORMATION

Broker/Consultant Name: _____ Agency/Firm Name: _____

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

Phone: (_____) _____-_____ Fax: (_____) _____-_____ Email: _____