Delta Dental of Illinois Application for Group/Employer Policy

Please type or print in black ink and complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

PROPOSED EFFECTIVE DATE OF GROUP/EMPLOYER POLICY

_____/_____/_____ ☐ New Application ☐ Change	☐ ASO ☐ Fully Insured
☐ Dental ☐ DeltaVision®* ☐ Both	Prior Carrier Information

APPLICANT INFORMATION

Legal Name of Group/Employer _____

Specify the legal name of the group/employer or the Taft-Hartley trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below.

GROUP/EMPLOYER BENEFIT PLAN MAY NOT BE NAMED.

Legal Address		**City**	**State**	**ZIP**
Business Address ***(if different than above)***		**City**	**State**	**ZIP**
Administrator Contact	**Title**	**Administrator Contact Phone** ( )	**Administrator Contact Email**	
Billing Contact ***(if different than above)***		**Billing Contact Phone** ( )	**Billing Contact Email** ***(if different than above)***	
Eligibility Contact ***(if different than above)***		**Eligibility Contact Phone** ( )	**Eligibility Contact Email** ***(if different than above)***	

BROKER/CONSULTANT SECTION

Broker/Consultant Name	**Agency/Firm Name**	
Address	**Phone**	**Email**

General Agent ***(if applicable)*** Euclid Managers

I certify as the group/employer that all requirements contained in this application have been met.

Name	**Title**
Signature	**Date** _____/_____/_____

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WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

The above signed certifies that s/he is authorized to apply for coverage for the selected Group/Employer dental/vision program on behalf of the named Group/Employer and to sign this application, and certifies the application has met all requirements listed below.

In making this application to Delta Dental of Illinois for the selected Group/Employer, the Group/Employer agrees and understands that this application will become part of the Contract/Administrative Services Contract executed by an authorized officer of Delta Dental of Illinois. The Group/Employer represents that all the information contained in the application is true and correct. Intentional 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 Group/Employer 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.

FOR FULLY INSURED CONTRACTS ONLY: The Group/Employer 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.

FOR ASO/SELF INSURED CONTRACTS ONLY: The Group/Employer agrees to fully underwrite the risk of the selected group dental/vision plan and accept liability for payment of benefits.

Application Requirements
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/Employer acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance.

The Group/Employer 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.

Group/Employer 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/employer application form.
- A completed dental and/or vision (as applicable) supplemental questionnaire.
- A signed rate quote.
- A deposit for the first month's premium.
- Enrollment. (For those waiving coverage, enrollment forms and supplemental 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.

**DeltaVision is underwritten by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, utilizing the EyeMed Vision Care networks.*