Delta Dental of Illinois Supplemental Questionnaire for Group/Employer Dental Policy

EUCLID MANAGERS

DELTA DENTAL®

GROUP/EMPLOYER INFORMATION

Group/Employer Name _____

BENEFIT PERIOD

Deductible and Maximum Accumulation:

☐ Contract Year ☐ Calendar Year ☐ Other _____

INITIAL ENROLLMENT

Total Number of Eligibles: _____

Total Number of Eligibles Enrolled: _____

GROUP/EMPLOYER CONTRIBUTION FOR DENTAL

The **group/employer** contributes:

☐ $_____ or _____% of the cost of the member's insurance.

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

☐ None (Coverage is voluntary)

ELIGIBILITY INFORMATION

PLEASE INDICATE ELIGIBILITY REQUIREMENTS FOR ENROLLMENT UNDER THE GROUP/EMPLOYER POLICY. *Enrollment under the group/employer policy will include (select all that apply):*

☐ A full-time hire regularly scheduled to work a minimum of 30 hours per week and is on the permanent payroll.

DELTA DENTAL PPO℠/DELTA DENTAL PREMIER®

New Hire Eligibility Date:

☐ Following _____ days of employment ☐ On the first of the month following _____ days of employment

☐ Date of hire ☐ Other: _____

Termination Occurs On:

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

Dependent children coverage is terminated on:

☐ Birthday ☐ Last day of the calendar month in which the limiting age is reached

Limiting Age

The limiting age for covered dependent children is 26.

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DELTACARE (DHMO)

New Hire Eligibility Date:

On the first month following _____ days of eligibility.

Termination Occurs On:

Termination is on the last day of the calendar month in which such person ceases to meet the definition of eligible person.

Limiting Age

The limiting age for covered dependent children is 26.

PREMIUM PAYMENTS

Monthly Billing Delivery Information ☐ Online Billing ☐ Paper

Summary Billing includes the summary of enrollees, prior balance, adjustments, current billed and total due by location with a grand total for all locations. If group/employer has multiple locations, does the group/employer require **Summary Billing**? (Fully insured groups/employers only.)

☐ Yes ☐ No

If **ACH Debit**, please supply banking information:

Bank Name: _____

Account Number: _____ Routing Number: _____

REMARKS/ADDITIONAL INFORMATION

_____

_____

Please note: Attach your selected plan design with accepted rates/fees when submitting this form.