DELTA DENTAL

SMALL BUSINESS PROGRAM
GROUP DENTAL and VISION APPLICATION

Dental:
Delta Dental of New Jersey, Inc.
1639 Route 10
Parsippany, NJ 07054
800-624-2633

Vision:
Delta Dental of Connecticut, Inc.
148 Eastern Blvd, Suite 301
Glastonbury, CT 06033
844-442-0014

APPLICANT INFORMATION			
Name of Applicant:	Fed. ID/TIN:		
Contact:	Phone:		
Email:	Fax:		
Address:			
City:	State:	ZIP Code:	County:
Industry Type:	SIC:		
Billing Address, if different:			
Billing Contact:	Phone:		Fax:
Billing Email:			
Situs State: New Jersey	Group Type: Employer	Contract Type: Non Retention	Length of Contract: One Year
Proposed Effective Date:	Open Enrollment Month *(if different from renewal date)*:		
Recipient of Electronic Documents and Notices: ☐ Applicant ☐ Other (provide name and email, address or fax number):			

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your contract-related documents including those that you will distribute to your group enrollees made available to you electronically. If you choose to have your contract(s)-related documents made available to you electronically, the terms & conditions below apply.

1. Communication Methods: All communications that we provide to you in electronic form will be provided either (1) by accessing Delta Dental's website with your username and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic document disclosure, and any other document that is important to you.
2. Types of Documents that Will Be Electronically Communicated: Documents available electronically include, but are not limited to: your contract(s), Benefits Summary Booklet(s) for your enrollees and your notifications, including the HIPAA Notice of Privacy Practices.
3. How to Withdraw Consent: You may withdraw your consent to transact business and receive notifications electronically by contacting Delta Dental. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic communications. A withdrawal of your consent to transact business and receive notifications electronically will be effective only after we have had a reasonable period of time to process the request.
4. How to Update Your Records: It is your responsibility to provide us with true, accurate and complete email address, and to maintain and update promptly any changes to this information. You can update your information by contacting Delta Dental's designated administrator.
5. Hardware and Software Requirements: In order to access, view, sign and retain electronic documents that we make available to you, you must:
    - Have a device that will connect to the Internet, have access to an email account and have access to an internet browser.
    - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download or print documents.
    - Be able to view the disclosures or notifications on your device.
    - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.

☐ **Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents and notifications, including the HIPAA Notice of Privacy Practices provided electronically.**

RESET

Applicant accepted on: _____
Delta Dental Group #: _____

DELTA DENTAL BENEFIT DESIGNS – Underwritten by Delta Dental of New Jersey, Inc.

Select Dental Benefit Design

Plan	☐ PPO		☐ PPO Plus Premier	
	Groups 2-9	**Groups 10-50**	**Groups 2-9**	**Groups 10-50**
☐ Plan 1	☐ $500 ☐ $750	☐ $500 ☐ $750	☐ $750/$500 ☐ $1,000/$750	☐ $750/$500 ☐ $1,000/$750
☐ Plan 2	☐ $1,000 ☐ $1,250	☐ $1,000 ☐ $1,250	☐ $1,000/$750 ☐ $1,250/$1,000	☐ $1,000/$750 ☐ $1,250/$1,000
☐ Plan 3	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $5,000	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan 4	*Plan not offered*	☐ $1,500 ☐ $2,000 ☐ $5,000	*Plan not offered*	☐ $2,000/$1,500 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan 4-Enhanced Ortho 1500	*Plan not offered*	☐ $1,500 ☐ $2,000 ☐ $5,000	*Plan not offered*	☐ $2,000/$1,500 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan 4-Maximum Ortho 2000	*Plan not offered*	☐ $1,500 ☐ $2,000 ☐ $5,000	*Plan not offered*	☐ $2,000/$1,500 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan 5	☐ $1,500 ☐ $2,000	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500 ☐ $2,000 ☐ $5,000	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $5,000/$4,500
☐ Plan 6	*Plan not offered*	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500 ☐ $2,000 ☐ $5,000	*Plan not offered*	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $5,000/$4,500
☐ Plan 6 Enhanced Ortho 1500	*Plan not offered*	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500 ☐ $2,000 ☐ $5,000	*Plan not offered*	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $5,000/$4,500
☐ Plan 6 Maximum Ortho 2000	*Plan not offered*	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500 ☐ $2,000 ☐ $5,000	*Plan not offered*	Deductible ☐ $50/$150 ☐ $75/$225 CYM ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $5,000/$4,500
☐ Plan 7	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500

Plan	☐ PPO		☐ PPO Plus Premier	
	Groups 2-9	Groups 10-50	Groups 2-9	Groups 10-50
☐ Plan 8	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $5,000	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000	☐ $1,000/$750 ☐ $2,000/$1,500 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan PPO Plus Premier 90	*Plan not offered*	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000	☐ $2,000/$1,500 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan A	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500
☐ Plan B	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500
☐ Plan B Enhanced Ortho 1500	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500
☐ Plan B Maximum Ortho 2000	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500
☐ Plan C	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000	☐ $2,000 ☐ $2,500 ☐ $3,000	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan D	*Plan not offered*	☐ $2,000 ☐ $2,500 ☐ $3,000	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan D Enhanced Ortho 1500	*Plan not offered*	☐ $2,000 ☐ $2,500 ☐ $3,000	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan D Maximum Ortho 2000	*Plan not offered*	☐ $2,000 ☐ $2,500 ☐ $3,000	*Plan not offered*	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000 ☐ $3,000/$2,500 ☐ $5,000/$4,500
☐ Plan V1	☐ $500 ☐ $750	☐ $500 ☐ $750	*Plan not offered*	☐ $500 ☐ $750
☐ Plan V2	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,500/$1,000 ☐ $2,000/$1,500

Plan	☐ PPO		☐ PPO Plus Premier	
	Groups 2-9	**Groups 10-50**	**Groups 2-9**	**Groups 10-50**
☐ Plan V3	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500	☐ $1,500/$1,000 ☐ $2,000/$1,500
☐ Plan V4	*Plan not offered*	☐ $2000	*Plan not offered*	☐ $2,000/$1,500
☐ Plan V5	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500	☐ $1,000/$750 ☐ $1,500/$1,000 ☐ $2,000/$1,500
☐ Plan V6	☐ $1,000 ☐ $1,250	☐ $1,000 ☐ $1,250	☐ $1,000/$750 ☐ $1,250/$1,000	☐ $1,000/$750 ☐ $1,250/$1,000
☐ Plan VA	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $3,000/$2,500
☐ Plan VC	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000	☐ $2,000 ☐ $2,500 ☐ $3,000	☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000	☐ $1,500/$1,000 ☐ $2,000/$1,500 ☐ $2,500/$2,000 ☐ $3,000/$2,500 ☐ $5,000/$4,500

DELTA DENTAL BENEFIT DESIGNS – Underwritten by Delta Dental of New Jersey, Inc.

Select Benefit Design

Plan	☐ PPO	
	Groups 2-9	Groups 10-50
☐ EHB Enhanced Family PPO III	☐	☐
☐ EHB Enhanced Family PPO III (1500)	☐	☐

DELTA DENTAL BENEFIT DESIGNS – Underwritten by Delta Dental of New Jersey, Inc.

Select Benefit Design

Plan	☐ Pediatric Plans	
	Groups 2-9	Groups 10-50
☐ PPO Basic Essential Plan	☐	☐
☐ PPO Enhanced Essential Plan	☐	☐
☐ PPO Plus Premier Basic Essential Plan	☐	☐
☐ PPO Plus Premier Enhanced Essential Plan	☐	☐

ELIGIBILITY INFORMATION

Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):

# of Eligible Employees:	# of Enrolled Employees:	# of Employees on Continuation:	Prior Carrier:

Eligible Individuals (check applicable boxes): ☐ Eligible Employees All employees working _____ hours

Eligible Dependents (check applicable boxes): ☐ Spouse /Civil Union Partner ☐ Children ☐ Domestic Partner ☐ Other

Eligible Requirement (check one):
☐ Date of hire ☐ First of the month following date of hire ☐ First of the month following _____ days of employment

ERISA INFORMATION

ERISA Applies ☐ Yes ☐ No
Plan details same as Applicant? ☐ Yes ☐ No, if "no" then provide information below:
Plan Sponsor:
Plan Sponsor's Employer I.D.
Plan Administrator:
Agent for Service of Legal Process:
Plan Number:

DENTAL FUNDING

Employer Contribution and Participation Requirement (check one):

☐ 50%-99% (75% of eligible employees, 50% of eligible dependents)	☐ 0% ☐ 1%-49.9% (Voluntary Plans Only) (25% of eligible employees)	☐ 100% (All eligible employees)
For groups with 10 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 10 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 10 or more eligible employees: All eligible employees must enroll.
For groups with 2-9 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 2-9 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 2-9 primary enrollees: All eligible employees must enroll.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

MONTHLY RATES

	Rates		#Primary Enrollees		Total
3 Tier					
EE Only	$	x		=	$ 0.00
EE+1	$	x		=	$ 0.00
EE + Family	$	x		=	$ 0.00
				TOTAL	$ 0.00

MONTHLY RATES – PEDIATRIC PLANS

	Rates		#Primary Enrollees		Total
3 Tier					
EE Only	$	x		=	$ 0.00
EE+1	$	x		=	$ 0.00
EE + Family	$	x		=	$ 0.00
				TOTAL	$ 0.00

DELTAVISION BENEFIT DESIGNS – Underwritten by Delta Dental of Connecticut, Inc. and Administered by Vision Service Plan Insurance Company ("VSP")

Select Vision Benefit Design

- ☐ DeltaVision - Essential
- ☐ DeltaVision - Brilliance
- ☐ DeltaVision - Premium
- ☐ DeltaVision - Platinum

ELIGIBILITY INFORMATION

Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):

# of Eligible Employees:	# of Enrolled Employees:	# of Employees on Continuation:	Prior Carrier:

Eligible Individuals (check applicable boxes): ☐ Eligible Employees All employees working _____ hours

Eligible Dependents (check applicable boxes): ☐ Spouse/Civil Union Partner ☐ Children ☐ Domestic Partner ☐ Other

Eligible Requirement (check one):

☐ Date of hire ☐ First of the month following date of hire ☐ First of the month following _____ days of employment

ERISA INFORMATION

ERISA Applies ☐ Yes ☐ No

Plan details same as Applicant? ☐ Yes ☐ No, if "no" then provide information below:

Plan Sponsor:

Plan Sponsor's Employer I.D.

Plan Administrator:

Agent for Service of Legal Process:

Plan Number:

VISION FUNDING

Employer Contribution and Participation Requirement (check one):

☐ 50%-99% (75% of eligible employees, 50% of eligible dependents)	☐ 0% ☐ 1%-49.9% (Voluntary Plans Only)	☐ 100% (All eligible employees)
For groups with 10 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 10 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 10 or more eligible employees: All eligible employees must enroll.
For groups with 2-9 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 2-9 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 2-9 primary enrollees: All eligible employees must enroll.

MONTHLY RATES

	Rates		#Primary Enrollees		Total
3 Tier					
E Only	$	x		=	$ 0.00
EE+1	$	x		=	$ 0.00
EE + Family	$	x		=	$ 0.00
				TOTAL	$ 0.00

BROKER/AGENT INFORMATION				
Broker/Agent Name:		State Broker License Number:		
Contact Phone :	Contact Email:		Fax:	
Company Name:		SSN/TIN:		
Commission Mailing Address:		City:	State:	ZIP Code:
Commission(s):		Renewal Contact Name and Email address:		
Broker/Agent Signature:			Date:	

GENERAL AGENT INFORMATION				
General Agent Name:		State Agent License Number:		
Contact Phone :	Contact Email:		Fax:	
Company Name:		SSN/TIN:		
Commission Mailing Address:		City:	State:	ZIP Code:
Commission(s):		Renewal Contact Name and Email address:		
General Agent Signature:			Date:	

Application is made for a dental contract from Delta Dental of New Jersey, Inc. and/or a vision contract from Delta Dental of Connecticut, Inc. (both hereinafter referred to as "Delta Dental"). Applicant understands and agrees that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the application. Applicant understands and agrees that, regardless of the proposed effective date that appears in the Applicant Information section above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta Dental and is accepted, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered for issuance of a dental and/or vision benefit contracts by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant.

This plan shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. The statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may void or result in cancelation or termination of contract and the ability of the applicant and its covered members to receive benefits if, had the true facts been known to Delta Dental we would not in good faith have issued the contract or issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility list will be submitted to Delta Dental by the 25th of the month prior to the coverage month.***

Applicant agrees that it shall be responsible for administering continuation of coverage for eligible employees and/or dependents, including responsibility for providing all required notifications, determining eligibility based on qualifying events, submitting individual enrollment forms to Delta Dental, collecting premiums, and informing Delta Dental when the employee is no longer eligible for continuation of coverage.

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta Dental's designated administrator with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental and/or vision contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental and/or vision plans as described in the group dental and/or vision insurance contracts or as permitted or required by law. Delta Dental and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/ addendum that may be required as part of the group dental and/or vision benefit contracts to be executed between the Applicant and Delta Dental.

The dental and/or vision contract does not include coverage of pediatric dental and/or vision services that meet essential health benefit requirements of the federal Patient Protection and Affordable Care Act or similar provision of state law, unless for dental coverage, a pediatric dental plan is elected.

Any person who includes any false or misleading information on an application for a [dental] [and/or] [vision] benefit contract is subject to criminal and civil penalties.

Executed this_____ day of _____ 20 __, for the Applicant at: _____
(City and State)

By: _____ Signature: _____
(Print Name and Title)

Delta Dental Authorized Signature: _____
(Barry Petruzzi, Vice-President, Underwriting & Actuarial)

Authorization for Eligibility/Enrollment/ Enrollment Web Portal Access (PHI Form)

I, _____, am authorized on behalf of _____ [insert name of Group and DDNJ/DDCT assigned group number] to identify the individuals listed below as authorized to receive a username and password to access the Delta Dental eligibility and enrollment portal and access to information regarding eligibility and enrollment.

I understand that eligibility and enrollment information and reports as well as access to the enrollment web portal contain information subject to federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), and contain information such as the names, home addresses, dates of birth, and social security numbers of individuals and dependents enrolled in the benefits plan (Enrollment Data).

I understand that a person can have different roles when they access Enrollment Data and the web portal. These roles include the following:

- **View** – allows a person access to view and receive enrollment reports or information. (no password to access web portal).
- **Modify** – allows a person to view and receive enrollment reports or information; and allows a person to add and delete eligibility; also allows a person to modify enrolled employee and dependent information, such as address for our group benefit plan (no password to access web portal).
- **Password** (includes View and Modify through the web portal) – allows a person to obtain a password to access the web portal to view and modify Enrollment Data.

Each of the individual(s) whose names appear below are authorized for the following access and roles:

Name and Address	Email Address	Phone Number	View (Y or N)	Modify (Y or N)	Password (Y or N)

Delta Dental shall be entitled to rely on any additions, deletions, or modifications to the Enrollment Data entered by an authorized individual listed above.

I understand that each of the individuals listed above will have access to Enrollment Data that is the subject of federal and state privacy, security, and data breach laws and that each understands that their access, use, and disclosure of this information shall be limited to an authorized business purpose related to administration of the benefits plan provided by Delta Dental.

I understand that I have an ongoing responsibility to provide Delta Dental with prompt written notice if any individual listed above no longer has permission to view or modify Enrollment Data or to have a username and password to the Enrollment Web Portal. I agree to provide written notice to the email address listed below to allow Delta Dental to disable the user account of any person no longer authorized to access the Enrollment Data or the Delta Dental enrollment portal.

Print Name_____

Signature_____

Title_____

Email_____

Telephone Number_____

Mailing and Email Address
Delta Dental of New Jersey, Inc.
Delta Dental of Connecticut, Inc.
1639 Route 10
Parsippany, NJ 07054
PHIForms@DeltaDentalNJ.com