

# DELTA DENTAL & VISION SERVICE PLAN EMPLOYER APPLICATION



EMPLOYER INFORMATION																							
Company Name		DBA																					
Address and Suite #																							
City		State	Zip																				
Billing Address (if different)			Suite																				
City		State	Zip																				
Contact Name		E-mail																					
Phone		Fax																					
BUSINESS INFORMATION																							
Date Business Established		SIC Code (required)																					
<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other																				
PLAN INFORMATION																							
Coverage Applying For: <input type="checkbox"/> Dental only <input type="checkbox"/> Vision only <input type="checkbox"/> Dental & Vision																							
DENTAL ELIGIBILITY INFORMATION																							
Requested Effective Date		Prior Carrier	Cancel Date																				
Total Number of Employees		Total Number of Eligible Employees	Total Number of Enrolling Employees																				
DELTA DENTAL CHOICE, CLASSIC, DELTACARE PLAN SELECTION (5-99 ENROLLING EMPLOYEES)																							
Choice (Non-Voluntary); 5-99		Classic (Non-Voluntary); 5-49		DeltaCare; 5-99																			
<b>Premier Plans</b> <input type="checkbox"/> Choice Premier 1000 <input type="checkbox"/> Choice Premier 1500 <input type="checkbox"/> Choice Premier 2000  <b>Optional Child Orthodontia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>Orthodontia is available to groups of 10 or more enrolling employees.</i>  <b>Employer Contribution</b> Employee: <u>100%</u> (required) Dependent: _____ (minimum 50%)		<b>PPO Plans</b> <input type="checkbox"/> Choice PPO 1000 <input type="checkbox"/> Choice PPO 1500 <input type="checkbox"/> Choice PPO 2000  <b>D&amp;P Max Waiver</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Optional Child Orthodontia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Orthodontia is available to groups of 10 or more enrolling employees.</i>  <b>Employer Contribution</b> Employee: _____ (minimum 75%) Dependent: _____ (minimum 0%)		<b>DeltaCare Choice HMO</b> <input type="checkbox"/> Plan 10B, Non-Voluntary  <b>Employer Contribution</b> Employee: <u>100%</u> (required) Dependent: _____ (minimum 50%)  <b>DeltaCare HMO</b> <input type="checkbox"/> Plan 10A <input type="checkbox"/> Plan 11A <input type="checkbox"/> Plan 12A <input type="checkbox"/> Plan 15B  <b>Participation/Employer Contribution Options</b> <input type="checkbox"/> <b>Option A, Non-Voluntary</b> Employee: _____ (minimum 75%) Dependent: _____ (minimum 75%)  <input type="checkbox"/> <b>Option B, Non-Voluntary for Employee</b> Employee: _____ (minimum 75%) Dependent: _____ (minimum 0%)  <input type="checkbox"/> <b>Option C, Voluntary</b> (Available for Dual Choice with Vol PPO only)																			
		Classic (Voluntary)																					
		<input type="checkbox"/> <b>Voluntary PPO</b> <input type="checkbox"/> Waive waiting period  <b>Optional Child Orthodontia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Orthodontia is available to groups of 25 or more enrolling employees.</i>  <b>Employer Contribution</b> Employee: _____ (0% to 74%) Dependent: _____ (0% to 74%)																					
DELTA DENTAL OPTIONS PLAN SELECTION (50-99 ENROLLING EMPLOYEES)																							
Options Standard Plans (Non-Voluntary)			Optional Plan Features																				
<b>PPO Plans</b> <input type="checkbox"/> Options PPO1 <input type="checkbox"/> Options PPO2 <input type="checkbox"/> Options PPO3  <b>Employer Contribution</b> Employee: _____ (minimum 75%) Dependent: _____ (minimum 0%)			Choose only those optional benefits you wish to elect. If standard benefit is desired, please leave blank.  <table style="width:100%; border: none;"> <tr> <td style="width: 33%;"></td> <td style="text-align: center; border-bottom: 1px solid black;"><b>STANDARD</b></td> <td style="text-align: center; border-bottom: 1px solid black;"><b>OPTIONS</b></td> </tr> <tr> <td><b>Deductible</b></td> <td>\$50 individual/\$150 family (PPO3 \$40/\$120 in network; \$50/\$150 out)</td> <td><input type="checkbox"/> \$25/\$75 (PPO3 \$0/\$0 in network; \$25/\$75 out)</td> </tr> <tr> <td><b>Orthodontia</b></td> <td>Not covered</td> <td><input type="checkbox"/> Child only    <input type="checkbox"/> Adult &amp; Child</td> </tr> <tr> <td><b>Ortho Lifetime Max</b></td> <td>Choose one if ortho selected</td> <td><input type="checkbox"/> \$1,000    <input type="checkbox"/> \$1,500</td> </tr> <tr> <td><b>Endo/Perio</b></td> <td>Covered as Basic Service</td> <td><input type="checkbox"/> Covered as Major Service</td> </tr> <tr> <td><b>D&amp;P Max Waiver</b></td> <td>Not covered</td> <td><input type="checkbox"/> D&amp;P Max Waiver</td> </tr> </table>				<b>STANDARD</b>	<b>OPTIONS</b>	<b>Deductible</b>	\$50 individual/\$150 family (PPO3 \$40/\$120 in network; \$50/\$150 out)	<input type="checkbox"/> \$25/\$75 (PPO3 \$0/\$0 in network; \$25/\$75 out)	<b>Orthodontia</b>	Not covered	<input type="checkbox"/> Child only <input type="checkbox"/> Adult & Child	<b>Ortho Lifetime Max</b>	Choose one if ortho selected	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500	<b>Endo/Perio</b>	Covered as Basic Service	<input type="checkbox"/> Covered as Major Service	<b>D&amp;P Max Waiver</b>	Not covered	<input type="checkbox"/> D&P Max Waiver
	<b>STANDARD</b>	<b>OPTIONS</b>																					
<b>Deductible</b>	\$50 individual/\$150 family (PPO3 \$40/\$120 in network; \$50/\$150 out)	<input type="checkbox"/> \$25/\$75 (PPO3 \$0/\$0 in network; \$25/\$75 out)																					
<b>Orthodontia</b>	Not covered	<input type="checkbox"/> Child only <input type="checkbox"/> Adult & Child																					
<b>Ortho Lifetime Max</b>	Choose one if ortho selected	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500																					
<b>Endo/Perio</b>	Covered as Basic Service	<input type="checkbox"/> Covered as Major Service																					
<b>D&amp;P Max Waiver</b>	Not covered	<input type="checkbox"/> D&P Max Waiver																					

# DELTA DENTAL & VISION SERVICE PLAN EMPLOYER APPLICATION (continued)

VISION ELIGIBILITY INFORMATION		
Requested Effective Date	Prior Carrier	Cancel Date
Total Number of Employees	Total Number of Eligible Employees	Total Number of Enrolling Employees
VISION SERVICE PLAN SELECTION (2+ ENROLLING EMPLOYEES)		
<b>Signature Plans</b>		<b>Value Plans</b>
<input type="checkbox"/> Plan A \$25 <input type="checkbox"/> Plan B \$25 <input type="checkbox"/> Plan C \$10 <input type="checkbox"/> Plan B \$0 / \$20 <input type="checkbox"/> Plan C \$0 / \$20 <input type="checkbox"/> Plan B \$10 Voluntary <input type="checkbox"/> Plan C \$10 Voluntary <input type="checkbox"/> Exam Plus		<input type="checkbox"/> Plan A20 <input type="checkbox"/> Plan A25 <input type="checkbox"/> Plan B20 Voluntary
<b>Vision Plan Employer Contribution</b> Employee: _____ (minimum contribution is 100% for all plans except the voluntary plans) Dependent: _____ (minimum 0%)		
<b>A \$15 administrative fee is charged each month to all VSP groups.</b> <b>New groups with 2 to 4 employees are charged a discounted administrative fee of \$10 per month, guaranteed for one year.</b>		
PROBATIONARY PERIOD		
<b>FOR VSP:</b> Eligibility begins on the first on the month following 3 months unless you wish to match your existing medical probationary period.  Please indicate probationary period if matching medical coverage: <input type="checkbox"/> Date of Hire* <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Other: <small>*First of month following date of hire</small>		<b>FOR DELTA DENTAL:</b> Eligibility begins on the first on the month following: <input type="checkbox"/> Date of Hire* <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Other: <small>*First of month following date of hire</small>
DOMESTIC PARTNERS		
Are domestic partners being allowed to enroll in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, will opposite gender domestic partners be eligible to enroll in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are the children of domestic partners eligible to enroll in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PAYMENT		
Please make check payable to "CoPower" and submit with your Employer Application and any other enrollment paperwork. This is a pre-paid plan; monthly payments are due the last day of the month before coverage.		
EMPLOYER SIGNATURE		
Signature of Company Officer		Date
Name (print)		Title (print)
PRODUCER STATEMENT (must be completed for commissions to be paid)		PRODUCER STATEMENT (must be completed for commissions to be paid)
Date		Date
Producer's Signature		Producer's Signature
Producer's Name (print)		Producer's Name (print)
Federal Tax ID or SSN		Federal Tax ID or SSN
Company Name		Company Name
Address		Address
City		City
State / Zip		State / Zip
Telephone		Telephone
Fax		Fax
E-mail		E-mail
Make commissions payable to: <input type="checkbox"/> Producer <input type="checkbox"/> Agency		Make commissions payable to: <input type="checkbox"/> Producer <input type="checkbox"/> Agency
Multiple producer split: <input type="checkbox"/> Yes <input type="checkbox"/> No		Multiple producer split: <input type="checkbox"/> Yes <input type="checkbox"/> No
Percentage of split _____ %		Percentage of split _____ %