DELTA DENTAL
Delta Dental Plan of Massachusetts

New Business Group Application

Attn: Sales Department
465 Medford Street
Boston, MA 02129
tel: 1-800-451-1249
Fax: (617) 886-1129
www.deltamass.com

To ensure fast processing of your application, please complete the below information in its entirety. The purpose of this form is to confirm the level of dental benefits, rates and billing information for your organization. Acceptance of your application is subject to Delta Dental Plan's Underwriting approval.

Group Information

Account Name: _____ Tax ID #: _____
Address: _____ Previous Carrier: _____
City: _____ State: _____ Zip: _____
Phone: ( ) _____ Fax: ( ) _____
HR Director: _____ E-mail address: _____
Day-to-Day Contact _____ E-mail address: _____
Billing Contact _____ E-mail address: _____

Coverage

Coverage period: From: / /
To: / /

Term of Agreement : ❑ One Year ❑ Two Years
❑ Other _____

Dental Plan

❑ DeltaPremier
❑ DeltaPremier USA
❑ Premier Voluntary
❑ DeltaCare (1) (2) (3)
❑ DeltaCare USA (1) (2) (3)
❑ DeltaPreferred Option USA
❑ DeltaPreferred Option USA Plus
❑ Preferred Voluntary
❑ Value Plan

Plan Design

Plan Design	Standard Plan	Other
Type I	❑ 100%	❑ _____%
Type II	❑ 80%	❑ _____%
Type III	❑ 50%	❑ _____%
Annual Max:	❑ $1,000	
	❑ $1,500	
	❑ $_____	

Deductibles	Standard	Other
	❑ None	❑ $ _____
	❑ $25/$75	❑ $ _____
	❑ $50/$150	❑ $ _____

Riders	Standard Plan	Other
Children to Age:	❑ 19	❑ _____
Students to Age:	❑ 23	❑ _____
Ortho to Age:	❑ 19	❑ To any age
	❑ Ortho LTM _____	

Participation Verification

Total number of employees: _____

Number of employees eligible for dental benefits: _____

Number of employees you are enrolling in the plan: _____

Number of employees waiving benefits due to coverage through a spouse or another reason: _____ (a letter or proof of waiver may be required)

Rate & Subscriber Count

	Premium Rates		Subscriber Count		Total
Individual	$_____	x	_____	=	_____
Employee +1	$_____	x	_____	=	_____
Family	$_____	x	_____	=	_____
Total	*******		_____		$_____

Company Contribution

Your Company Contribution must be at least 50% of the total monthly premium that is listed in the total column in the Rate and Subscriber count box. This does not apply to the Premier Voluntary, Preferred Voluntary and Value Plans.

Your first month's premium should = this total

Company Contribution Must = 50%

Billing Options

❑ Fully-Insured

First month's $_____ premium due w/ application

❑ Self-Insured

❑ Administrative Rate _____%
❑ Per subscriber per month rate $_____
Deposit due w/ application $_____

Enrollment

Initially ❑ Forms ❑ Electronic Tape
Ongoing ❑ Forms ❑ Electronic Tape
Date enrollment will be sent by: / /

Broker Information

Broker Information (if applicable)

Contact Name: _____
Firm: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: ( ) _____
Signature: _____

I hereby apply for the Delta Dental Plan of Massachusetts plan as outlined above and I designate the broker named on this form (if applicable) hereon to act on our organization's behalf.

Company Representative Signature: _____

Title: _____ Date: _____

Delta Dental Plan Internal Use Only

Underwritring Approval: _____ Group Number Assigned: _____-_____ Additional Sub-locations: _____, _____, _____

Pink Copy - Group Yellow Copy - Finance White Copy - Sales