APPLICATION

MaxiMizer

Group Information

Employer (Group) ______________________________

Address ______________________________
Street P.O. Box City State ZIP

Phone ( ) _______ - _________ Fax ( ) _______ - _________

Nature of business ______________________ Years in business _______ SIC code _______

Previous dental carrier ______________________ Effective date ____________

Have you been cancelled by another dental benefits carrier in the past 36 months? _________

Current health carrier ______________________ Effective date ____________

Contact information

Benefit contact ______________________ Billing contact ______________________

Title ______________________ Title ______________________

E-mail address ______________________ E-mail address ______________________

Plan Design

Plan Chosen	Annual Max.	Deductible	Ortho Max.	Endo/Perio Coverage
❑ MaxiMizer Premier	❑ $2,000	❑ $25/$75	❑ $2,000	❑ Standard
❑ MaxiMizer Savings PPO	❑ $1,500	❑ $50/$150	❑ $1,500	❑ Upgraded
❑ MaxiMizer Enhanced PPO	❑ $1,000	❑ $75/$225	❑ $1,000	
			❑ No ortho	

Employer contribution: _____% _____% OR _____% _____% _____% _____%
Employee Family Employee Emp./Spouse Emp./Child(ren) Emp./Spouse/Child(ren)

Total number of eligible employees: __________ Total number employees enrolled: __________
(Include completed waivers for those not enrolling)

Requested effective date: ______________ Waiting period for new employees: ______________
(Must be at least the first of the month following 30 days of employment)

Rates: _______ _______ OR _______ _______ _______ _______
Employee Family Employee Emp./Spouse Emp./Child(ren) Emp./Spouse/Child(ren)

(Need help calculating rates? Use the worksheet in the rates section of this form)

Dual choice with DeltaCare? ❑ Yes ❑ No (If yes, please complete information on the opposite side of this form)

Employer Agreement

In making this application to Delta Dental Plan of Wisconsin (DDPW) for group dental coverage under this program, the Group agrees and understands this application will become part of the Contract executed by an authorized officer of DDPW. It is agreed that the coverage requested is subject to the approval of DDPW and that no agent or representative has authority to make or modify this application for coverage. The Group hereby certifies that all of the above information is true and correct. The Group understands that coverage will not be effective until questions regarding eligibility for coverage have been satisfactorily resolved. The Group agrees to be bound by the terms of the Contract issued by DDPW to the extent it does not conflict with this application. Misrepresentation of submitted data will cause this application and subsequent Contract to be null and void.

Signed: ______________________ Name: ______________________

Title: ______________________ Date: ______________________

Agent Statement: As the acting representative for the group represented in this application, I have to the best of my knowledge and ability complied with the underwriting guidelines listed by Delta Dental Plan of Wisconsin.

Agent's Name ______________ Fed. ID No. ______________ Agency ______________

Address ______________________________ Phone ( ) _______ - _________

License No. ______________ Soc. Security No. ______________ E-mail Address ______________

If commission is to be paid to someone other than above, please state: ______________________

Delta Dental Plan of Wisconsin is unable to accept this document with any changes, cross-outs, white-outs, etc. unless the person signing the application initials those changes. Approval of coverage is contingent upon underwriting acceptance.

DeltaCare Dual-Choice Information

Complete this section only if MaxiMizer plan is to be offered as a dual-choice option with DeltaCare.

Plan choice: ❑ Traditional ❑ Extra

Rates: ________ ________ OR ________ ________ ________ ________
Employee Family Employee Emp./Spouse Emp./Child(ren) Emp./Spouse/Child(ren)

Employer contribution: ______% ______% OR ______% ______% ______% ______%
Employee Family Employee Emp./Spouse Emp./Child(ren) Emp./Spouse/Child(ren)

Default DeltaCare Facility Location Code: __________
(Default location will be assigned to enrollees who choose DeltaCare but do not select a DeltaCare facility location on their enrollment form. See DeltaCare Dentist directory for facility location codes.)

To enroll a group

Provide the following to Delta Dental prior to the first of the month the coverage is to be effective:

- An application for group dental coverage completed and signed by the employer.
- Completed enrollment/waiver cards for all full-time employees.
- A check from the group for the first month’s premium.