SECTION 3

Continued from previous page. Complete this section only for self-funded groups.

Summary Plan Description

Delta Dental will gladly assist in the development of the group's Summary Plan Description, or suggest any necessary modifications of the group's SPD if they have developed their own. We just need your responses to the questions below.

1. **Choose one of the following two options:**
   - ☐ **The group will do its own Summary Plan Description.** *If choosing this option, you may skip the questions below. Please provide Delta with a copy of the SPD.*
   - ☐ **The group would like Delta to help develop the SPD.** *If choosing this option, please answer all of the remaining questions below.*
2. **Plan name:**
   ____
   (Example: ABC Company Group Dental)
3. **Plan sponsor's Employer Identification Number (EIN):**
   ____
   (Federally-assigned tax ID)
4. **Plan number for government reporting purposes:**
   ____
   (Assigned by employer, eg. 501 - Medical, 502 - Dental, 503 - Vision)
5. **Plan year and fiscal year:**
   Plan year ____________ Fiscal year ____________
6. **Send copy of SPD to agent?** ☐Yes ☐No
   If the group works with an insurance agent, Delta will send a copy of the completed SPD to that agent if the group wishes to do so.
7. **Contact information**
   Name or title, address and phone number of person or position at the group that legal papers are sent to:
   ____
   ____
   ____

   Plan administrator: (Name, address and phone).
   ____
   ____
   ____

   Contact for SPD followup: (Name, phone number and email address of person who will review the completed SPD).
   ____
   ____
   ____

ACH Financing Agreement

Automated clearinghouse (ACH) transfer of funds is a safe, easy and effective way to insure proper funding of the group's account. ACH transfers for claims paid will occur weekly. A fax will be sent to the person designated by the group one day prior to the transfer, providing the total amount to be withdrawn the following day. Administration charges are calculated monthly and are included in the final transfer of the month. At the end of the month, Delta will send a printout of claims paid and the account reconciliation. Claims and administrative charges will be itemized. To set up an ACH transfer, please complete the information below.

Contact Person (to receive the weekly fax) ____________ Contact Person's Phone ____________ Contact Person's Fax ____________

Depository Name ____________ Depository Transit/ABA Number ____________

Account Name ____________ Account Number ____________ ☐ Savings or ☐ Checking?

Depository Contact Person ____________ Depository Contact Person's Phone ____________

I (we) hereby authorize Delta Dental Plan of Wisconsin, Inc., hereinafter called Company, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account and the financial institution indicated below, herein called Depository, to debit and/or credit the same such account. This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name ____________ Name ____________

Signature ____________ Date ____________ Signature ____________ Date ____________

Delta Dental Plan of Wisconsin

Group Application Form

Please use this form only for nonpooled risk and ASO (Administrative Services Only) groups. For plans to be written under one of Delta Dental's pooled plans (MaxiMizer, Preferred Access, TriSelect Voluntary Plus, Total Access Voluntary or DeltaCare), please use the group application form contained in the brochure for each product. 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.

Application will be considered after Delta Dental receives:

- ☐ A completed group application form (be sure to complete all required sections)
- ☐ A deposit check for the first month's premium (or, if ASO and choosing ACH, completed ACH form)
- ☐ A copy of the proposal outlining benefits
- ☐ Completed enrollment forms (For employees waiving coverage, enrollment forms must be submitted and must indicate that they are waiving coverage, and the reason for the waiver). Enrollment forms may not be required if some other eligibility reporting method is arranged in advance.

Stevens Point Headquarters
2801 Hoover Road, P.O. Box 828
Stevens Point, WI 54481
800.236.3713 Fax 715.344.9058

Milwaukee Sales Office
1233 North Mayfair Road, Suite 204
Milwaukee, WI 53226
888.456.2711 Fax 414.607.6088

Madison Sales Office
437 South Yellowstone Drive, Suite 200
Madison, WI 53719
887.577.7449 Fax 608.271.6001

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway, P.O. Box 8190
Madison, WI 53708-8190

SECTION 1 Complete this section for all groups

Group Information

Employer (Group) ______

Address ______ Street / P.O. Box / City / State / ZIP

Phone ( ) ______ Fax ( ) ______

Nature of business ______ SIC code ______

Are other dental plans offered? ☐Yes ☐No If yes, describe: ______

Previous dental carrier ______ Effective date ______

Current health carrier ______ Effective date ______

Address ______

Contact information

Billing/benefit contact ______ Title ______

E-mail address ______

Additional contact (optional) ______ Title ______

Employer association, group or coalition (if applicable) ______

Plan Design

Important: This section must be completed by the employer. All information must be provided.

The employer contributes ______ % of the single rate and ______ % of the family rate.

Total number of eligible employees ______ Total number enrolled ______ Total number not enrolled ______

Why not enrolled? ______

Are employees given the option of cash or other benefits if the dental plan is waived? ☐Yes ☐No

Number of employees outside of Wisconsin ______ Waiting period for new employees ______

Requested effective date ______ Benefits accumulation period ☐Contract year ☐Calendar year

Plan design number ______ Rates (or admin fee) selected ______

Agent Information

Agent Name ______ Agency Name ______

Address ______ E-mail ______

Phone ( ) ______ License No. ______ Social Security No. ______

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

Name ______ Fed. ID No. ______

Consultant's Name ______ Phone ( ) ______

Address ______ E-mail ______

Agent/Consultant Statement

As the acting representative for this Group, I have to the best of my knowledge and ability complied with the policies and procedures of Delta Dental Plan of Wisconsin.

Agent or Consultant's Signature: ______

Implementation Checklist

1. **Are employee meetings scheduled?** ☐Yes ☐No
   Would you like Delta Dental to assist in the meetings?
   ☐Yes ☐No
2. **Would you like introductory information sheets for employees?**
   ☐Yes ☐No
3. **Do you require billing by sub-division?**
   ☐Yes ☐No If yes, please attach list and billing contact information.
4. **Enrollment transmission:**
   ☐Tape/diskette ☐Paper forms ☐List
   Estimated receipt date: ______ or included ☐
5. **Would you like Delta Dental to provide ID cards?**
   ☐Yes ☐No
   ID cards will be mailed to human resources department of the group, unless otherwise specified. Options are available at an additional cost.
6. **Employees/dependents are covered to:**
   ☐Date of termination/birth date
   ☐End of month following termination/birth date
   ☐Other (please specify): ______
7. **Surgical coverage:**
   ☐Medical primary, dental secondary
   ☐Covered in medical plan only (please supply handbook)
   ☐Covered in dental plan only
   ☐Covered in dental plan only if excluded by medical

Continue for self-funded groups only

8. **Coordination of benefits:**
   ☐Standard
   ☐Nonduplication of benefits
9. **Do you anticipate that Delta Dental will administer run-in claims?** ☐Yes ☐No
   If yes, please provide the name and phone number of the contact person at the previous carrier: ______

SECTION 2 Complete this section only for fully-insured groups. For self-insured groups, skip to Section 3.

Employer Agreement: Fully-Insured Group

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.

Name: ______ Title: ______ E-mail: ______

Signature: ______ Date: ______

Approval of coverage is contingent upon underwriting acceptance.

SECTION 3 Complete this section only for self-insured groups. See Section 2 for fully-insured groups.

Employer Agreement: Self-Insured Group

The Group agrees and understands that this application will become part of the Third Party Administrative agreement executed by an authorized officer of Delta Dental Plan of Wisconsin. The Group agrees to be bound by the terms of the TPA agreement to the extent it does not conflict with this application.

Name: ______ Title: ______ E-mail: ______

Signature: ______ Date: ______

Section 3 continues on the next page.