



APPLICATION FOR A DENTAL CONTRACT

Delta Dental of New York
 Administrative Offices
 One Delta Drive, Mechanicsburg, PA 17055
 (800) 932-0783 TTY/TDD (888)373-3582

APPLICANT INFORMATION	Group Number: _____ Division(s): PPO plus Premier - Plan 4		
Name of Applicant: _____		Nature of Business: _____	
Address: _____			
City: _____	State: _____	Zip: _____	County: _____

CONTRACT TERM: From: _____ Through: _____ Contract Length: <u>2 Year</u>	<input checked="" type="checkbox"/> DUSA
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PROGRAM TYPE:

Delta Dental Premier DeltaCare USA
 Delta Dental PPO Flexible Dual Choice:
 Delta Dental PPO Plus Premier Annual
 Other: _____ Monthly

DEPENDENT COVERAGE:

X Spouse X Children to age 26, regardless of full-time student or marital status <input type="checkbox"/> Ortho to age _____	<input type="checkbox"/> Domestic Partners <input type="checkbox"/> Domestic Partner Dependents
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Standard - Exact Day

FREQUENCY LIMITATIONS:

Exams: 2 in any 12 Month period
 Prophylaxes: 2 in any 12 Month period
 Fluoride: 2 in any 12 Month period
 Bitewing x-rays: 2 in any 12 Month period

COORDINATION OF BENEFITS:

Regular
 Non-Duplication
 No Internal COB
 Primary for Impactions

BENEFITS TURNOVER PERIOD:

Calendar Year
 Contract Year
 (to)

UNIQUE LIMITATIONS OR EXCLUSIONS (Attach additional page if necessary)

Previous Group Dental Coverage? If so, please list dates and name of previous carrier.

SERVICES	PPO	Premier	Non-Par	SERVICES	PPO	Premier	Non-Par
Diagnostic	100 %	100 %	100 %	Posterior Composites	80 %	80 %	80 %
Preventive	100 %	100 %	100 %				
Basic Restorative	80 %	80 %	80 %				
Major Restorative	50 %	50 %	50 %				
Oral Surgery	80 %	80 %	80 %				
Endodontics	80 %	80 %	80 %				
Periodontics (<i>Surgical</i>)	80 %	80 %	80 %				
Periodontics (<i>Non-Surgical</i>)	80 %	80 %	80 %				
Prosthodontics	50 %	50 %	50 %				
Sealants	100 %	100 %	100 %				
TMJ	50 %	50 %	50 %				

DEDUCTIBLE(S)				MAXIMUM(S)			
	PPO	Premier	Non-Par	Based on:		Annual Max	Based on:
Per Enrollee	\$ 0	\$ 0	\$ 0		Per Enrollee	\$ 1500	Calendar Year
Per Family	\$ 0	\$ 0	\$ 0		Per Family	N/A	N/A
Orthodontics	N/A	N/A	N/A		Orthodontics	N/A	
Services Exempt from the Deductible:				<input type="checkbox"/> Diagnostic & Preventive <input type="checkbox"/> Sealants <input type="checkbox"/> Orthodontics <input type="checkbox"/> Other: _____			

CENSUS INFORMATION:

Total Number of Employees: _____

Number of Employees Eligible: _____

Number of Single: _____

Number of Two-Party: _____

Number of Family: _____

EMPLOYER CONTRIBUTION:

_____ Employees

_____ Dependents

REQUIRED PARTICIPATION:
A minimum of 5 employees or 50 percent of all eligible employees, whichever is fewer.

RATES: Monthly per Employee Type:

1st Year

Single: \$ 46.59 \$ _____

Two-Party: \$ 84.05 \$ _____

Family: \$ 119.56 \$ _____

RATING METHOD:

Prospective

Cost Plus

Retention

ASO/ERISA

Prefund: \$ _____

ADMINISTRATION OR RETENTION FEE:

% of claims % of premium

\$ _____ Per employee per month

Settlement: Claims: _____ by _____

Fee: \$ _____ by _____

ELIGIBILITY INFORMATION:

New Hire Eligibility:

Additions: Standard

Terminations: Standard

BROKER / CONSULTANT INFORMATION (if applicable)

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

E-mail Address: _____ Phone: () - - Fax: () - -

Commission Amount: _____ Commission Payable To: _____

SPECIAL REQUESTS (Attach additional page if necessary)

Medical Carrier _____

Application is herewith made for a dental service contract from Delta Dental of New York, Inc. (Delta). It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. 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. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta 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 service contract to be executed between the Applicant and Delta.

Dated on _____ Name of Applicant _____

By _____

Witness _____

Soliciting Agent _____

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.