



# 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

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

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

<p><input checked="" type="checkbox"/> <b>X Spouse</b></p> <p><input checked="" type="checkbox"/> <b>X Children to age 26, regardless of full-time student or marital status</b></p> <p><input type="checkbox"/> Ortho to age _____</p>	<p><input type="checkbox"/> Domestic Partners</p> <p><input type="checkbox"/> Domestic Partner</p> <p style="text-align: center;">Dependents</p>
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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		\$ 1500		Calendar year
Per Family	\$ 0	\$ 0	\$ 0		N/A		
Orthodontics	N/A	N/A	N/A		N/A		
<b>Services Exempt from the Deductible:</b>	<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: \$ 40.26 \$ \_\_\_\_\_  
 Two-Party: \$ 72.61 \$ \_\_\_\_\_  
 Family: \$ 103.28 \$ \_\_\_\_\_

**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.