Small Group Dental Insurance Application (2–50 employees)
Connect for Health Colorado Small Group Plans

DELTA DENTAL

Delta Dental of Colorado
4582 S. Ulster St. Ste. 800
Denver, CO 80237
Fax: 303-741-4233

Requested Effective Date: (must be first of month)

☐ New Group
☐ Renewing Group

For internal use only
Group Number:

Group Information

Legal Group Name:

Street Address:

City, State: Zip: Phone: Fax:

Administrative Contact Name:

Administrator's Email Address: Phone: Fax:

Billing Information

Billing Contact Name:

Street Address: City, State: Zip:

Billing Contact Email Address: Phone: Fax:

North American Industry Classification (NAICS) Code: Type of Industry: EIN/TIN:

Rates, Eligibility & Employer Contribution

Total number of eligible employees: Total number of enrolled employees: Employer contribution for employees (%):

Rates:
All rates listed are per month.

Per Adult | Per Child

Does group allow for same sex domestic partner coverage? ☐ Yes ☐ No

New Hire Waiting Period
Indicate the time period employees must wait before they become eligible for dental insurance.

☐ 1st of the month following 60 days
☐ Exact date of hire
☐ As determined by employer
☐ 1st of the month following ____ days
☐ 1st of the month following ____ months
☐ 1st of the month following date of hire

For groups of 25 or more employees:
Are there classes of employees with different eligibility periods?
☐ Yes* ☐ No

*If yes, select the first eligibility class:
☐ Class 1 ☐ Salaried/Exempt
☐ Class 2 ☐ Management
☐ Class 3 ☐ Executive
☐ Class 3 ☐ Other
☐ Hourly/Non-Exempt

*If yes, select the second eligibility class:
☐ Class 1 ☐ Salaried/Exempt
☐ Class 2 ☐ Management
☐ Class 3 ☐ Executive
☐ Class 3 ☐ Other
☐ Hourly/Non-Exempt

Indicate the eligibility waiting period for second class of employees:

Eligibility: All eligible employees (and dependents) who are employed by the group on the inception date of this plan are immediately eligible for coverage. Each present or new employee is an "eligible employee" if he or she 1) works the minimum number of hours required by the employer; 2) is certified as being eligible by the group; 3) receives compensation from the group; and 4) is a member of the group as specified in the Group Dental Contract. Note: Child ACA benefits are to age 19; dependent eligibility is to age 26, regardless of student status.

Product & Benefit Options ☐ Voluntary ☐ Contributory

Select a Product:

☐ Mesa PPO ☐ Summit PPO

Continued on the next page

Additional Information

Name of previous dental carrier:

Is this a prior Delta Dental group? ☐ Yes* ☐ No

*If yes, provide prior Delta Dental group number:

Contract Period: 12 months

Enrollment Method: Secure Employer Account Online

Signature

Signature of Authorized Group Administrator

Date

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable shall be reported to the Colorado Division of insurance within the Department of Regulatory Agencies.

Agent Information

Name:

Street Address:

City, State:

Zip:

Phone:

Fax:

Email Address:

Social Security or License Number:

Agency TIN:

Agency currently appointed with Delta Dental? ☐ Yes ☐ No*

*If no, please complete appointment paperwork online at www.deltadentalco.com/brokers.aspx

Commission payable to: ☐ Agent ☐ Agency**

**If commission is payable to agency, list agency here:

Please send completed and signed small group dental insurance application packet including the Group Health Plan Certification (HIPAA), Automatic Draft Authorization Form, Website Authorization Form, employee enrollment forms, prior carrier (bill if applicable), and estimated first month's premium payment to:

C4HCOnewgroupsales@ddpco.com

For any questions please contact Delta Dental of Colorado's new group sales team at:
1-800-610-0201, select option 3, then option 1

DELTA DENTAL

Group Health Plan Certification

The _____ Group Health Plan (Plan) does hereby certify to the following:

1. That the Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. That the Plan documents you distribute to employees informing them about their benefits or the Plan documents you are legally required to maintain for your employee benefits plans (such as ERISA Plan documents) have been amended, as required by 45 CFR §164.504(f) and §164.314(b) HIPAA, to incorporate the following provisions and you, as the Plan Sponsor (employer) agreed to:

    a. Not use or further disclose (Protected Health Information (PHI)) other than as permitted by plan documents or as required by law;
    b. Ensure that any agents, including subcontractors, to whom the plan sponsor provides PHI agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;
    c. Not use or disclose PHI for employment-related actions and decisions;
    d. Report any inconsistent use or disclosure of PHI to the group health plan;
    e. Make PHI available to an individual based on HIPAA's access requirements;
    f. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
    g. Make available the information required to provide an accounting of disclosures;
    h. Make internal practices, books and records relating to the use and disclosure of PHI received from the Group Health Plan available to the Secretary of Health and Human Services to determine the Plan's compliance with HIPAA;
    i. Ensure that adequate separation between the Group Health Plan and the Plan Sponsor is established as required by HIPAA (45 CFR §164.504(f)(2)(iii)) and that such separation is supported by reasonable and appropriate security measures;
    j. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible;
    k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan;
    l. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    m. Report to the group health plan any security incident of which it becomes aware.

1. The undersigned further certifies that he or she has the authority to sign on behalf of the Plan.

Printed Name of Plan Representative: _____

Signature of Plan Representative: _____

Delta Dental Group Number: _____ **Date:** _____

Delta Dental of Colorado puts a high priority on compliance with laws and regulations under which it operates and is dedicated to protecting the information of our enrollees.

DELTA DENTAL

Automatic Draft Authorization Form
For employer groups

Please complete the form and return it to the address listed below.

☐ New authorization

☐ Changes to existing authorization (changes will be completed within 10 days of receipt of this form)

Group Information	
Group Name:	Group Number:
Contact Name:	Phone:
Fax:	Email:

I (we) hereby authorize Delta Dental of Colorado, hereinafter called "Company," to initiate debit entries from our account indicated below and the bank named below. I understand that employer groups eligibility can be placed on hold for a rejected draft. I also understand that this specified account would be deducted no later than 48 hours after a claims premium invoice is sent to the group contact.

Account Information	
Account Type: ☐ Checking ☐ Savings	Financial Institution:
	Branch:
Transit ABA Number (Routing Number):	
Account Number:	

This authority is to remain in full force and effect until Company has received notification from us of termination in such a time and such a manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized Representative Signature:

Name: **Date:**

Self-Funded Groups Only
Please automatically draft: ☐ Administrative fees only ☐ Administrative fees + claims payment

Please return this completed form as part of the new group application and enrollment packet to salesteam@ddpco.com. See the cover sheet for all the required forms.

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Website Authorization Form

Purpose: This form allows a Plan Sponsor to open website accounts for authorized individuals and business associates for purposes of submitting enrollment information and obtaining access to group activity reports, eligibility reports, and bills. Access to certain reports may be contingent upon the type of protected health information (PHI) disclosed and whether the group is experience-rated. Please note that contract arrangements in which Delta Dental of Colorado (DDCO) assumes financial risk are referred to as experience-rated groups; whereas groups in which DDCO only provides administrative services are referred to as self-funded group.

Plan Sponsor Requesting Authorization	
Group Name:	Group Number:
Address:	
Telephone:	Email Address:

Fill out one form for each employee requiring access. Provide employee name, email, and phone number for the individual and identify the access authorized for that individual by checking the box next to the service. Please also supply a keyword in the event a password is forgotten (applicable only for those requiring a password).

☐ Add User ☐ Terminate User

Full Name:	
Telephone:	Email Address:
Keyword (choose one): Last 4 digits of SSN:	Pet Name: Mother's Maiden Name:

The group, acting through its undersigned representative, certifies that the individual identified above is authorized to access the checked options below and perform the functions associated with each option on the group's behalf and hereby authorizes DDCO to open a website account for the individual set forth above.

Enrollment	**View Invoices**	**Enrollment Access to Pay Bills**
☐ Full Access (adds, changes, terms)	☐ Yes	☐ Yes (incl. remittance page or ACH info.)
☐ View Only (for electronic filers)	☐ No	☐ No

☐ Receive electronic error (EE) reports

☐ Allow broker/consultant access to management reports

☐ Management Reports: Current reports available include summary level data about the performance of your dental plan, such as number of claims paid, premiums paid, enrollment by month, network utilization and cost containment savings.

☐ View Eligibility Recap Report (self-funded groups only): The Eligibility Recap Report provides a monthly recap of subscribers and dependents who are eligible for insurance under the group dental plan.

☐ View Group Activity Reports Level One (self-funded groups only): Provides a monthly summary of claims history that includes detailed subscriber level information.

☐ View Group Activity Reports Level Two (self-funded groups only): Provides a monthly summary of claims history without subscriber information.

AUTHORIZATION AND CONDITIONS FOR PRIVILEGES GRANTED.

In consideration for the privileges set forth in this Website Authorization form, the group, acting through it, hereby agrees to the following conditions:

1. DDCO may rely on electronically submitted enrollment data to the same extent as if submitted by non-electronic means;
2. Group will undertake reasonable measures to safeguard account information, including user name and password, and to prevent unauthorized access to the website by someone acting or purporting to act on the group's behalf;
3. All authorization requests (adds, changes, terms) need to be submitted via email to group_admin@ddpco.com or faxed to 303-741-9160;
4. Group shall be solely responsible for any liability arising from the use of the website account and shall indemnify, hold harmless, and defend DDCO against any claim arising from the authorized user's use of the website account or the group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws; and
5. The individual signing this application form has the authority to permit the requested access and bind the group to the terms and conditions set forth above.

Authorized Representative Signature:

Name: **Date:**