Group Insurance Application – Delta Dental Plan of New Mexico

Please email an electronic copy of your completed form to your Sales Executive

No person will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, race, color, national origin, gender identity, sex, or sexual orientation, religion, or other legally protected status.

Part A1 – Group Identification	Group # Sub-Group # (Delta Dental use)		☐ Small (2-50) ☐ Large (51 +) ☐ ASO ☐ Large (100 +)
Employer (Group) Name:		Group Requested Coverage Effective Date to start on the first day of: Month: ____ Year: ____	
Street Address:	City:	State:	Zip:
Mailing Address (If different than Street Address):	City:	State:	Zip:
Billing Address (If different than Street Address):	City:	State:	Zip:
Employer's Industry:	Federal Tax ID:	SIC/NAICS:	
Group Prior Carriers (If any):	Has this Group been covered previously by Delta Dental? If so, please specify: Group #: ____ Termination Date: ____		

Part A2 – Group Contacts	Contact Name	Phone Number	Email Address
Billing	First: Last:		
Benefits Administrator (Eligibility) Benefit Manager Toolkit	First: Last:		
Overage Dependent (Eligibility)	First: Last:		
Renewal	First: Last:		
Third Party Administrator	First: Last:		
Additional (Please specify):	First: Last:		

Part B – Agency Info	Agent Name	Phone Number	Email Address
Agency Name:	First: Last:		

Street Address:	City:	State:	Zip:
Mailing Address (if different than Street Address):	City:	State:	Zip:

Part C – Billing *Please indicate method of Initial and Monthly payments below:*

Initial Payment: ☐ ACH (Preferred; please attach complete ACH Authorization Form) ☐ If Other, please specify and connect with your Sales Executive: ____	Monthly Payment: ☐ ACH (Preferred; please attach complete ACH Authorization Form) ☐ If Other, please specify and connect with your Sales Executive: ____

Part D1 – Small Group Only (2-50) - Choose a Plan *Please attach to this application, a valid product flier or proposal, with the plan design and Rates indicated. Select your plan(s) below:*

☐ PPO 1500	☐ PPO 2500	☐ PPO 3000	☐ POS 1000	☐ POS 2000	☐ POS 5000
☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER
☐ Preventive	☐ Value	☐ Shared	☐ Deluxe	☐ Ultimate	
☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	☐ 3 TIER ☐ 4 TIER	

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Part D2 – Large Group Only (51 +) – *Please attach to this application, a proposal Summary of Benefits and Rate sheet with the plan design and Rates indicated.*

☐ Attach proposal Summary of Benefits from Delta Dental of New Mexico

☐ Attach plan design and [Rate sheet]

Part D3 – Large Group Only (100 +) or ASO – Proposal from Delta Dental of New Mexico *Please attach to this application, a proposal Summary of Benefits and Rate sheet with the plan design and Rates indicated.*

Special Benefit Provisions Requested, If Any. (note: if non-standard Benefits are elected, additional fees may apply for custom materials):

____

____

☐ Attach proposal Summary of Benefits from Delta Dental of New Mexico

☐ Attach plan design and Rate sheet

Part E1 – Eligibility Information *Please indicate the total amount of the following…*

Employees:	Full-time Employees:	Part-time Employees:	Eligible Employees (including Waivers):	Employees in Eligibility Waiting Period:

Eligibility Waiting Period for New Employees indicate Dental Benefits will go into effect on (select one):

☐ first day of the month following (date of hire)

☐ first day of the month following (30) days from date of hire

☐ first day of the month following (60) days from date of hire

☐ first day of the month following (90) days from date of hire

When an Employee is terminated, their Dental Benefits end:

☐ **(Small Group 2-50)** on the first day of the month following their last day of employment

☐ **(Large Group 51+ or ASO Group)** ☐ the first day of the month following their last day of employment **or** ☐ on their actual last day of employment

Domestic Partners - Delta Dental plans cover Domestic Partners at the same level as a Spouse. However, you may opt out of this coverage.

☐ opt out of Domestic Partner Coverage

Dependent Child Age Limitation – Dependent children are covered through the end of the month on their 26th birthday, unless physical or mental disability exception applies.

Allow IRS Dependents (Requires Rate Adjustment): Eligible Dependents for the selected plan(s) will include individuals who qualify as dependents under Internal Revenue Service (IRS) rules. According to the IRS, "A dependent is a person other than the taxpayer or spouse who entitles the taxpayer to claim a dependency exemption." Visit www.IRS.gov for help to determine who qualifies as an IRS dependent.

Part E2 – Employer Premium Contributions

Employer Contribution for Enrolled Employees: ____________ %

Employer Contribution for Enrolled Dependents: ____________ %

Part F – Required Supporting Documentation

A. Employer Group Insurance Application, signed and completed; and
B. Employee Group Plan Enrollment/Change Form, signed and completed; and
C. First month's premium payment (ACH Authorization Form preferred, or Binder Check); and

Part G – Important Deadlines and Effective Dates

Please submit completed Group Insurance Application and supporting documentation from Part F to your Sales Executive.

1. Submit completed documentation by the 15th of the month prior to the Group Requested Coverage Effective Date (in Part A1) to secure the requested coverage effective date.
2. Documentation received after the 15th of the month will instead have coverage effective on the first day of the month following original Group Requested Coverage Effective Date (in Part A1).

Part H – Employer Agreement

I understand the following: Coverage cannot be bound by my agent; My prior insurance plan, if any, should not be terminated until coverage is approved by Delta Dental; Coverage is subject to the Delta Dental Underwriting Guidelines, a copy of which is available to me upon request; and Delta Dental will not accept this application without a valid proposal attached. I acknowledge that if Delta Dental accepts this application, it will become the basis of and included in the [Group Dental Insurance Contract] written by Delta Dental for my Group, and I believe that all information provided herein is accurate to the best of my knowledge. I acknowledge that by paying the first month's Premium, I will be accepting the terms of the [Group Dental Insurance Contract] for this[/these] Plan[(s)].

Type/printed name of Group Officer: ______________________ Title: ______________________

Executed this ____________ day of ______________________, 20 ____________

Authorized Signature (Group Officer) ______________________________

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Part I – Agent Agreement (for Agent Use Only)

Individual Agent Name: ____________________ Agency Name: ____________________

Signature: ____________________ Date: ____________________

Part J – Delta Dental Information (for Delta Dental Use Only)

Delta Dental Sales Executive: ____________________ Delta Dental Account Manager: ____________________