Fully Insured
New Group Application
and Enrollment Packet

Welcome to Delta Dental of Colorado. We appreciate your business and want to get you on board as efficiently as possible. This packet contains all the forms you will need to fill out and return to us to get set up in our system. Please complete and return all the forms together, including the employee enrollment forms. This helps us ensure that we have all the necessary information for your company to be effective upon your requested date.

If you are completing the forms on your computer, please make sure to do a **Save As** and add the name of your company to the file name. You can scan your employees' enrollment forms and add them to the PDF to send in if you wish (*Send eligibility as an Excel spreadsheet attachment. Please do not submit in PDF format.*) Or you can print everything out and mail it. The contact information is included below. If you need help completing these forms or have any questions, please contact your Delta Dental of Colorado sales executive.

REQUIRED FORMS

- ☐ Fully Insured new group application form
- ☐ Product and benefit options
- ☐ ACH authorization form
- ☐ Employer portal authorization form
- ☐ Group health plan certification
- ☐ Broker portal authorization form

Please send the completed and signed Fully Insured application packet as detailed above, along with all the subscriber enrollment forms, to:

Delta Dental of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

Fully Insured
New Group Dental Application

Please complete this application in its entirety. For quicker and more accurate processing, please save this form to your computer, rename the file, and type your responses.

Group Information

Requested Effective Date: Must be 1st of the month	**For Delta Dental use only** Group #: Sublocations (divisions):
Legal Group Name:	EIN/TIN:
Street Address:	

City, State:	ZIP Code:	Phone:	Fax:

Group Contact's Information

Contact Name:		Contact Title:
Phone:	Fax:	Email Address:

Other Contact Information (Only complete this section if billing information is different than above.)

Billing Entity Name:	Third Party Administrator (TPA): ◯ Yes ◯ No	
Address:	City, State:	ZIP Code:

Contact Name:	Contact Title:	
Phone:	Fax:	Email Address:

Product Selection

Plan 1: Single Option: (Select a Product)

- ◯ Delta Dental PPO Plus Premier™
- ◯ PPO Reimbursement Maximum Allowable Charge (MAC)
- ◯ Delta Dental PPO™
- ◯ Delta Dental Premier®
- ◯ Delta Dental Patient Direct®
- ◯ Other, (please describe in box)

Plan 2: Dual Option Dental Products (Select Products)

- ◯ Delta Dental PPO Plus Premier
- ◯ PPO Reimbursement Maximum Allowable Charge (MAC)
- ◯ Delta Dental PPO
- ◯ Delta Dental Premier
- ◯ Delta Dental Patient Direct
- ◯ Other, (please describe in box)

Other: Vision & Hearing (Select a Products)

- ◯ Delta Dental Patient Direct
  ◯ 3–Tier ◯ 4–Tier
- ◯ DeltaVision® 150 Plan
  ◯ Voluntary ◯ Contributory
- ◯ DeltaVision 200 Plan
  ◯ Voluntary ◯ Contributory
- ◯ DeltaVision 175 Plan+ EasyOptions Plan
  ◯ Voluntary ◯ Contributory
- ◯ DeltaVision One & Sun
  ◯ Voluntary ◯ Contributory
- ◯ DeltaHearing®
  ◯ Voluntary ◯ Contributory
- ◯ Other, (please describe in box)

Employee Participation and Employer Contribution

Total number of eligible employees:	Total number of enrolled employees:	Employer contribution toward employee (%):	Employer contribution toward dependents (%):

Other employer contribution information:

Employee Eligibility

New hire waiting period, determined by employer: Amount of time employees must wait before eligible for benefits.

Dependents covered to age 26?

◯ Yes	◯ No
If no, indicate dependent age:	

Same-sex domestic partner coverage?

◯ Yes	◯ No

Civil Union coverage?

◯ Yes	◯ No

Rates

Plan 1 | Single Option | Check this box if rates are net commission ☐

Tier 4

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family

Tier 3

Employee Only	Employee + 1	Employee +2 or More

Tier 2

Employee Only	Employee + Family

Plan 2 | Dual Option

Tier 4

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family

Tier 3

Employee Only	Employee + 1	Employee +2 or More

Tier 2

Employee Only	Employee + Family

Other | DeltaVision® | Fully Insured

Tier 4

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family

Tier 3

Employee Only	Employee + 1	Employee +2 or More

Tier 2

Employee Only	Employee + Family

Other | DeltaHearing™

Employee Only

General Information

Name of previous dental carrier:		Prior Delta Dental group number (if applicable):	
NAICS (industry code):	Is a Schedule A 5500 required? ◯ Yes ◯ No	Web reporting? ◯ Yes* ◯ No	* If yes, requires additional information for security purposes.

Enrollment, Payment, and Billing

Initial enrollment method:
Choose one:

◯ DDCO Spreadsheet	◯ EE/EDI
◯ Web Tool	◯ Paper

Ongoing enrollment method:

◯ EE/EDI	◯ Web Tool

Payment method:
Groups with less than 10 enrolled employees must select ACH.
Claims:

◯ ACH	◯ Wire	◯ Check

Contract Information and Signatures

Group Effective Date

Benefit Period for Deductible/Maximum:
◯ Calendar year (Small Group Standard)
◯ Contract year

Contract Period
◯ 12 Months
◯ 24 Months
◯ 36 Months
◯ Other - (Please explain in box)

If you selected "Other" for Contract Period, please provide more information.

It is agreed that the Group Contract will not become effective unless/until this application is approved and accepted by Delta Dental of Colorado. It is understood that this application will be considered part of the contract between Delta Dental of Colorado and the group listed above.

Signature of Authorized Group Representative **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 and 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.

Producer Information

Producer Name:	Agency Name:	
Street Address:		
City, State:	ZIP Code:	TIN/SSN:
Email:	Phone:	Fax:
Do you currently receive commissions from Delta Dental? ◯ Yes ◯ No	Web reporting*? ◯ Yes ◯ No	* If yes, requires additional information for security purposes.

General Agency Information (if applicable)

General Agency Name:	Contact:	
Street Address:		
City, State:	ZIP Code:	TIN/SSN:
Email:	Phone:	Fax:
Do you currently receive commissions from Delta Dental? ◯ Yes ◯ No	Web reporting*? ◯ Yes ◯ No	* If yes, requires additional information for security purposes.

Please send completed and signed Self-Funded Group Dental Application, original quote, ACH or Wire Authorization form, Employer Portal Authorization form, HIPAA certificate for Fully Insured groups or BAA for Self-Funded groups, and employee enrollment forms (if applicable) to:

Delta Dental of Colorado
6465 Greenwood Plaza Blvd., Ste. 900
Centennial, CO 80111-4901

Sales and Client Services
salesteam@ddpco.com

DELTA DENTAL

Product and Benefit Options

Attach: Sold plan quote(s) with rate sheet(s) for all options.

Note: Please include original quote for all Small Group plans.

☐ Delta Dental Standard & Enhanced Plans (2–9 enrolled employees)*
*Please include original quote with New Group Dental Application

Select a Pool
◯ Pool A
◯ Pool B

Select a Plan: Standard
◯ Standard PPO 1500
◯ Standard PPO 2000
◯ Standard PPO Plus Premier 1000
◯ Standard PPO Plus Premier 1500
◯ Standard PPO Plus Premier 2000

Select a Plan: Enhanced
◯ Enhanced PPO 1500
◯ Enhanced PPO 2000
◯ Enhanced PPO Plus Premier 1000
◯ Enhanced PPO Plus Premier 1500
◯ Enhanced PPO Plus Premier 2000

☐ Delta Dental Flex Choice (10–49 enrolled employees)*

◯ Flex Choice Plan A	◯ Flex Choice Plan B	◯ Flex Choice Plan C
◯ Flex Choice Plan D	◯ Flex Choice Plan E	◯ Flex Choice Plan F

☐ Delta Dental Flex Choice | Custom Plan Options

Please select one option from each category:

Contract
◯ Standard Contract
◯ Enhanced Contract

Deductible
◯ $0
◯ $25/$75
◯ $50/$150
◯ $75/$225

Annual Maximum
◯ $750
◯ $1,000
◯ $1,250
◯ $1,500
◯ $2,000
◯ $2,500

Endo/ Perio
◯ Basic
◯ Major

Right Start 4 Kids®
◯ Yes
◯ No

Prevention First
◯ Yes
◯ No

Implants
◯ Yes
◯ No

☐ Orthodontic Riders

Select One:	◯ Adult	◯ Child

Select One: Ortho Lifetime Maximum	◯ $1,000	◯ $1,500	◯ $2,000

☐ Delta Dental Clear Plans (10–99 enrolled employees)

Select a Pool:	◯ Pool A	◯ Pool B	
Select a Plan:	◯ Clear Value	◯ Clear Value +	◯ Clear Premium

☐ Delta Dental Ultimate Choice (50–99 enrolled employees)
*Please include original quote and Plan Summary.

☐ Delta Dental Large Group (100+ enrolled employees)
*Please include original quote with New Group Dental Application

☐ Delta Dental/Kaiser Permanente Small Group Dental Plans*				
Select a Plan:	○ 11671 (Formerly 1851) Standard Option	○ 11671 (Formerly 1851) Standard plus Ortho Option	○ Adult Only Comprehensive Option	○ Adult Only Comprehensive Option 2

☐ Delta Dental/COPIC/CMS Dental Program				
Select a Plan:	○ High Option	○ Low Option	○ Delta Dental Plus Premier (Includes Child-Only Orthodontia)	○ Delta Dental PPO

☐ Delta Dental Patient Direct® Savings Plan

☐ DeltaVision®			
Select a Plan:	○ DeltaVision 150 Plan	○ DeltaVision 200 Plan	○ DeltaVision 175 + EasyOptions Plan

☐ DeltaHearing®

Additional Comments:

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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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:	

Authorized Representative Signature:	
Name:	Date:

Self-Funded Groups Only

Please automatically draft:

- ○ Administrative fees only
- ○ Claims only
- ○ Administrative fees + claims payment

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DELTA DENTAL®

Employer Portal Authorization Form

This form allows a plan sponsor to open an account on the secure employer portal for authorized individuals and business associates for purposes of submitting enrollment information and obtaining access to group activity reports, and 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.

***Additional forms required for each authorized individual.**

Plan Sponsor Requesting Authorization

Group Name:

Group Number:

*If specific sub and sub-sub account access is needed, please specify the numbers. If only the top account number is provided, access to all sub and sub-sub accounts will be granted.

Fill out one form for each employee requiring access. Provide user name, email, and phone number for the individual and identify the access authorized for that individual by checking the box next to the service.

○ Add User ○ Terminate User

Full Name:

Telephone:

Email:

The group, acting through its undersigned representative, certifies that the individual identified above is authorized to access the web roles listed below and perform the functions associated with each option on the group's behalf and hereby authorizes DDCO to open a portal account for the individual set forth above (access requires password).

Only one box should be selected from each of the three sections below

Role
○ Eligibility and Reporting (not available for Small Group Pool)
○ Eligibility, Bills, and Reporting (not available for Small Group Pool)
○ Reports Only (not available for Small Group Pool)
○ Eligibility and Bills (only available for Small Group Pool)
○ Eligibility Only (only available for Small Group Pool)

View/Modify
○ View
○ Modify (Modify access is not available for electronically filed groups. If modify access is needed for members not submitted on the file, select modify above, but note that electronically filed members will still default to view only)

Account Type
○ Fully Insured
○ Self-Funded
○ Small Group Pool (Kaiser Small Group, Small Group Direct & COPIC)

Employee Statuses and Departments: *Please specify any specific employee statuses (active, COBRA, LOA, etc.) that you need access to manage/view, as well as any group specific departments. If access to all employees and all departments are needed, this field can be left empty.

Reports include:

- **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.
- **Eligibility Error Report:** The Eligibility Error Report provides detail and descriptions of enrollment errors that need to be corrected on the eligibility file. (only for electronically filed groups)
- **Eligibility Recap Report (self-funded groups only):** The Eligibility Recap Report provides a monthly recap of subscribers and dependents that are eligible for insurance under the group dental plan.
- **Group Activity Reports (self-funded groups only):** Provides a monthly summary of claims history that includes detailed subscriber level information.
- **Claims-Level Access to Facilitate Client-Managed Customer Service (self-funded groups only):** Provides individual member benefits and claims information to employee or other designee of self-funded group for use in group-administered customer service functions.

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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 requests (adds, changes, terms) need to be submitted via email to **salesteam@ddpco.com**. DDCO shall have three business days (excluding holidays) to process such requests;
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:**

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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Group Health Plan Certification (HIPAA)

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.

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DELTA DENTAL

Broker Portal Authorization Form

This form allows plan sponsors to authorize Delta Dental of Colorado to open an account on the secure broker portal for authorized individuals/agencies for purposes of submitting enrollment information and obtaining access to group activity reports, eligibility reports, and bills on their behalf. A plan sponsor can also request to have access removed for previously authorized individuals by selecting the appropriate box below.

Access to certain reports may be contingent upon the type of Protected Health Information (PHI) disclosed and whether the group is experience-rated. Signing this form permits your broker to access the aforementioned PHI.

***Additional forms required for each authorized individual.**

Plan Sponsor Requesting Authorization

Group Name:	
Group Number:	
*If specific sub and sub-sub account access is needed, please specify the numbers. If only the top account number is provided, access to all sub and sub-sub accounts will be granted	

Fill out one form for each broker requiring access. Provide full name, email, and phone number for the individual and identify the authorized access for that individual by checking the box next to the service.

○ Add User ○ Terminate User: Existing Email/Username:

Broker's Full Name:	
Broker Agency TIN/Tax ID:	
Broker's Telephone:	
Broker's Email:	

The group, acting through its undersigned representative, certifies that the individual identified above is authorized to access the web roles listed below and perform the functions associated with each option on the group's behalf and hereby authorizes DDCO to open a broker portal account for the individual set forth above. Only one box should be selected from each of the three sections below.

Role
○ Eligibility and Reporting (not available for Small Group Pool)
○ Eligibility, Bills, and Reporting (not available for Small Group Pool)
○ Reports Only (not available for Small Group Pool)
○ Eligibility and Bills (only available for Small Group Pool)
○ Eligibility Only (only available for Small Group Pool)

View/Modify
○ View
○ Modify (Modify access is not available for electronically filed groups. If modify access is needed for members not submitted on the file, select modify above, but note that electronically filed members will still default to view only)

Account Type
○ Fully Insured
○ Self-Funded
○ Small Group Pool (Flex Choice, Delta Dental Patient Direct®, Kaiser Small Group, & COPIC)

Employee Statuses and Departments*: *Please specify any specific employee statuses (active, COBRA, LOA, etc) that you need access to manage/view, as well as any group specific departments. If access to all employees and all departments are needed, this field can be left empty.

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Reports include:

- 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.
- Eligibility Error Report The Eligibility Error Report provides details and descriptions of enrollment errors that need to be corrected on the eligibility file. (only for electronically filed groups)
- Eligibility Recap Report (self-funded groups only): The Eligibility Recap Report provides a monthly recap of subscribers and dependents that are eligible for insurance under the group dental plan.
- Group Activity Reports (self-funded groups only): Provides a monthly summary of claims history that includes detailed subscriber level information.

○ Claims-Level Access to Facilitate Client-Managed Customer Service (self-funded groups only): Provides individual member benefits and claims information to employee or other designee of self-funded group for use in group-administered customer service functions.

AUTHORIZATION AND CONDITIONS FOR PRIVILEGES GRANTED.
In consideration for the privileges set forth in this Portal Authorization form, the group and user, 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 shall be solely responsible for authorizing only appropriate individuals, groups, and Business Associates.
3. User will undertake reasonable measures to safeguard account information, including protecting and not sharing username and password, and to prevent unauthorized access to the portal by someone acting or purporting to act on the group's behalf;
4. All requests (adds, changes, terms) need to be submitted via email to **DeltaDentalHub@ddpco.com**. DDCO shall have three business days (excluding holidays) to process such requests;
5. The group is solely responsible for submitting timely requests for termination of user access that is no longer needed (three business days).
6. Group shall be solely responsible for any liability arising from the use of the portal account and shall indemnify, hold harmless, and defend DDCO against any claim arising from the authorized user's use of the portal 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
7. 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:** ____________________

Please return this completed form as part of the New Group Application and Enrollment Packet
to **salesteam@ddpco.com**.
If this is in reference to an existing group, please email the form to **DeltaDentalHub@ddpco.com**.

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