Delta Dental of North Carolina
(Delta Dental)

Master Dental Contract Application
Pooled Programs

PART A – COMPANY INFORMATION

Legal Company Name ______________________________

Address ______________________________ Phone ( ) ______________

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City ______________________________ State __________ Zip Code __________

Plan Effective Date: ______________________________

Eligibility probationary period for new employees: First of month following: __________ Other: ______________

(North Carolina state law: No longer than 90th day of employment)

Type of Coverage: ☐ Employee Only ☐ Employee and Dependents

Does your company currently have a dental plan? ☐ No ☐ Yes (name of carrier)

(Attach copy of most recent billing statement) Length of coverage:

PART B – PARTICIPATION

TOTAL NUMBER OF ELIGIBLE EMPLOYEES __________________

Delta Dental Premier Program

☐ 5-14 Eligible Employees – 100% of all employees and 100% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. One time enrollment.

☐ 15-99 Eligible Employees – 100% of all employees and 75% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. Annual open enrollment for dependents only.

☐ 15-99 Eligible Employees – 80% of all employees and 80% of dependents not covered elsewhere must enroll. A minimum of five (5) employees must enroll. One time enrollment.

Delta Dental Indemnity Program

☐ Your group must have five or more eligible employees. A minimum of five (5) employees must enroll. One time enrollment.

☐ **MEDICAL LOCK** (Applies to all Plans. Must include a copy of most recent medical billing statement.)

PART C – DENTAL PROGRAM (Choose One):

Delta Dental Premier Program (Employer Paid)

Deductible: (Choose One)	☐ $100 per person (lifetime) ☐ $25/$75 per person/per family (calendar year) ☐ $50/$150 per person/per family (calendar year)
Annual Maximum: (Choose One)	☐ $1,000 escalating maximum ☐ $1,000 per person/per calendar year ☐ $1,500 (per person/per calendar year for groups of 30 or more enrolled employees)

Delta Dental Indemnity Program (Voluntary)

Endodontic and Periodontal Services to be covered at: ☐ 50% ☐ 80%

Annual Maximum: (Choose One)	☐ $500 ☐ $750 ☐ $1000
Deductible: (Choose One)	☐ $25 per person/per calendar year ☐ $50 per person/per calendar year

Optional 12-month waiting period for Major Restorative Services? ☐ Yes ☐ No

PART D – ORTHODONTICS – Orthodontics is available with a minimum of 10 employees enrolled.

Do you want Orthodontic coverage? ☐ Yes ☐ No
Does the prior dental plan have Orthodontic coverage? ☐ Yes ☐ No
For Delta Dental Indemnity Program: Optional 12-month waiting period for Orthodontic Services? ☐ Yes ☐ No
Available only for dependent children, age 8-18. Eligible services are covered at 50% with a $1,000 orthodontic-specific lifetime maximum (separate from other services).

Waiting Periods – Plans with waiting periods work as follows:

- For new groups not covered by a prior existing dental plan, the published waiting periods apply.
- For groups that have had at least 12 consecutive months of comparable coverage, waiting periods (a) are waived for employees enrolling in the plan at the group's Delta Dental effective date and (b) applied for all employees joining the group or enrolling in the plan after the effective date.

RATES

Employee:	Employee + Spouse:	Employee + Child(ren)	Family:
$	$	$	$

AGENT OF RECORD (if any) Completion of all fields required

Name ______________________ Agency ______________________

Address ______________________ Phone ( ) ______________________

City ______________________ State __________ Zip Code __________

______________________ ______________________

Agent Signature / NC Insurance Agent License ID Number

Tax ID Number

Note: Commissions will be paid to this TIN.

PREMIUM REMITTANCE AND SUBMISSION

The first month's premium must accompany the application. Thereafter, the monthly premium payment and the corresponding statement or invoice must be received by the first of each month.

1. Select Payment Option:

   ☐ ACH - Include ACH Authorization Form and voided check

   ☐ CHECK ☐ WIRE
2. Complete application. Retain a copy for your files.
3. Have each employee complete and sign a Membership Enrollment Form.
4. Send the original application, completed Membership Enrollment Forms and the first month of premium to:

   Delta Dental of North Carolina
   730 S. Broadway
   Gilbert, MN 55741
   ATTN: DELTA DENTAL CONNECT

For questions call 1-888-332-4617 or email dconnect@deltadentalnc.org.

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than five.

Delta Dental will return a contract upon acceptance of the application. The contract will indicate the effective date of coverage. The contract is effective only after Delta Dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental.

SIGNATURE BOX

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Signature of Authorized Company Official Title Date

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Group Administrator/Future Correspondence Contact (please print) Title

( ) ( )

Phone Number Fax Number Email Address