

APPLICATION FOR A DENTAL CONTRACT

Delta Dental of New York, Inc. Administrative Offices One Delta Drive, Mechanicsburg, PA 17055 (800) 471-7091 TTY/TDD (888)373-3582

APPLICANT II	NFORMATIO	ON Group	Number:	Division(z).							
APPLICANT INFORMATION Group Number: Dividing Name of Applicant:					Nature of Business:							
Address:	*****				radic of Dusiness.							
City:				State:	Zip:	- (County:					
CONTRACT T	ERM: From	n: T	hrough:	Contra	Contract Length: <u>months</u>							
NETWORK TYPE: DEPENDENT COVERAGE:												
☐ Delta Dental Premier ® ☐ DeltaCare ® USA					☑ Spouse		☐ Domestic Partners					
Delta Dental PPO Delta Dental PPO Flexible Dual Choice:					☐ Spouse ☐ ☐ Spouse ☐ ☐ Children to age 26 Standard — Exact Day				Domestic Partner			
Delta Dental PPO Plus Premier Annual					✓ Students to age 26 Standard — Exact Day				Dependents			
								· ·				
	☐ Monthly ☐ Ortho to age 19 Standard — Exact Day											
FREQUENCY	LIMITATIO	NS:		COO	RDINATION OF B	ENEFITS:	BENEFITS	BENEFITS TURNOVER PERIOD:				
Exams:	Twice in a	ny Calendar Ye	ear period	⊠ Re	⊠ Regular			☐ Calendar Year				
Prophylaxes:	Twice in a	ny Calendar Ye	ear period	□ N	☐ Non-Duplication			☐ Contract Year				
Fluoride:	Twice in a	ny Calendar Ye	ear period	1 1	o Internal COB	((to)					
Bitewing x-rays:		ny Calendar Ye	-	1 1	imary for Impaction							
		-	•		(Attach additional		sarv)					
Enhanced Benef			□ No		(F G	3)					
Group purchased	_	-		coverage: 🛛	Yes No							
anniu ana	1	nno.		001	GERNAGES	, pp.o	nno n					
SERVICES		PPO	Premier 80%		OON SERVICES		PPO 0%	Premio				
Diagnostic Preventive		100%	80%	80% 80%			%		% 0% % %			
Preventive 100% 80% Basic Restorative 80% 60%			60% Denture Repair		50%	509						
		50%	50%	+	50% Denture Relining		50%	50				
Oral Surgery 80%		60%	60%				509					
Endodontic		80%	60%	60%	Crown Recementa	ition	50%	509	% 50%			
Periodontic (Sur				50%	509	% 50%						
Periodontic (Non	Periodontic (Non-Surgical)		60%	60%	Bridge Recementation		50%	509	% 50%			
Prosthodontic		50%	50%	50%			%	•	%			
Orthodontic		50%	50%	50%			%	•	% %			
Sealants		100%	80%	80%			%		%			
TMJ		50%	50%	50%			%	(%			
DEDUCTIBLE	(S)				MAXIMUM(S)							
	PPO	Premier	OON	Based on:	222.20.2(8)	PPO	Premier	OON	Based on:			
Per Enrollee	\$ 50	\$ 75	\$ 75	Calendar Year	Per Enrollee	\$ 1500		\$ 1000	Calendar Year			
Per Family	\$ 150	\$ 225	\$ 225	Calendar Year		\$	\$	\$				
Orthodontics	\$	\$	\$	2	Orthodontics	\$	\$	\$				
			stic & Prevent	ive 🛛 Sea		*	Ψ	Ψ				
Services Exempt from the Deductible:		Other:										
Services Exempt from the Maximum:		☐ Diagnostic & Preventive ☐ Sealants ☐ Other:										
		Other:										

CENSUS INFORMATION:		EMPLOYER CONTRIBUTION:			RATES: Monthly per Employee Type:				
Total Number of Employees:		% Employees			1st Year				
Number of Employees Eligible:		% Depe	endents	Sin	igle:	\$	\$		
Number of Single:				Tw	o-Party:	\$			
Number of Two-Party:		REQUIRED PARTICIPATION:		Th	Three-Party+: \$ \$				
Number of Three-Party+:		75% Employees			Family: \$ \$				
		<u>50%</u> Depe	endents	Co	mposite:	\$	\$		
RATING METHOD:	ADMINICTO	ATION OR RETENTION	ON EEE.		EL ICIDII I	EX INE	ORMATION:		
Prospective									
Cost Plus				New Hire Eligibility: DOH First of month following: date of hire; days of employment.					
Retention	r employee per month								
☐ ASO/ERISA	Cattlement	Cl.:			Additions: Standard				
Prefund: \$	Settlement:	Settlement: Claims: by			Terminations: Standard — End of Month				
Prefund: 5		Fee: by							
BROKER / CONSULTANT I	NFORMATION	N (if applicable)							
Company Name:		11 /							
Address:									
City:				State:		Z	ip: -		
Contact Person:			Title:						
E-mail Address:			Ph	one: () -		Fax: () -		
Commission Amount:		Commission Payable	To:						
CDECIAL DECLIERTS (Attack	h additional page	if necessary)							
SPECIAL REQUESTS (Attac	h additional page	e if necessary)							
SPECIAL REQUESTS (Attac	h additional page	e if necessary)							
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	h additional page	e if necessary)							
Medical Carrier	h additional page	e if necessary)							
Medical CarrierApplication is herewith made for	r a dental service	contract from Delta Dent			,		nt this Application is offered as an		
Medical Carrier Application is herewith made for inducement for issuance of a dent	r a dental service tal service contrac	contract from Delta Dentet by Delta. Such contract	will be based ex	clusively	on the informat	ion giver	to or acquired by Delta from this		
Medical Carrier Application is herewith made for inducement for issuance of a dent Application. To that end, the sig that the answers are true. No wai	r a dental service tal service contrac ner of the Applica iver or modification	contract from Delta Dent et by Delta. Such contract ation declares that he/she on of the Application shall	will be based ex has read the state be accepted unle	clusively ements an ess in wri	on the informated answers above ting and signed	ion giver e and tha by an aut	n to or acquired by Delta from this at to the best of his/her knowledge chorized officer of Applicant. It is		
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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.

Delta Dental of New York, Inc. Small Business Program

SUPPLEMENT TO GROUP APPLICATION

APPLICANT INFORMATION								
Applicant's Name:	EIN:			4-digit SIC code:				
State where company is headquartered:								
Will this Delta Dental program replace coverage currently through another do ☐ No ☐ Yes, name of carrier:	Number of Employees Participating in DeltaCare® USA Program: Total Enrollees:							
CONTACT PERSON INFORMATION								
Contact Person:	Title:							
Contact Phone: () -			Contact Email:					
Contact Fax Number: () -								
Billing address (if different from Applicant):				State:			Zip:	
DUAL CHOICE AND ENROLLMENT INFORMATION								
Dual Choice with a DeltaCare USA Program? (Y/N): Minimum for Enrollment: 5 Primary Enrollees								
DELTACARE USA PROGRAM (check one)								
☐ Plan 13A	☐ Plan M73 (not available in NY state							
EMPLOYER CONTRIBUTIONS (check one)								
□ 0% - 49.9%	□ 75% - 100%							
DELTACARE USA RATES (complete the following if client applying for DeltaCare USA)								
Enrollee Only: (# of enrollees) x \$ monthly premium rates) = \$								
Enrollee & 1 Dependent: (# of	monthly premium rates) = \$							
Enrollee & Family: (# of enrollees) x \$			monthly premium rates) = \$					
= \$								
BROKER (WRITING AGENT) INFORMATION								
Name:)								
Company name:	Company is incorporated? (Y/N):							
Tax ID or SSN:	State & State License #:							
GENERAL AGENT ("GA") INFORMATION - OFFICE USE ONLY								
GA COMPANY NAME:								
GA SALES REPRESENTATIVE:								
☐ LEVEL ONE ☐ LEVEL TWO								