



Application for Group Dental Plan

Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
(605) 224-7345 Fax (605) 224-0909
1-800-627-3961
www.deltadentalsd.com

Requested effective date _____

GROUP INFORMATION

Group name (as it is to appear on the contract) _____

Street address _____ P.O. Box _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail address _____ Nature of business _____

Person in charge _____ Title _____

Contact for eligibility information _____ Phone _____

Contact for billing information _____ Phone _____

Coverage year will be _____ through _____

Subsidiary or affiliated companies (companies under common control through stock ownership, contract or otherwise) whose employees are to be covered:

Are separate billings required for these companies? _____ Yes _____ No

Location name	Address	Contact person & phone #
_____	_____	_____
_____	_____	_____

EMPLOYEE INFORMATION

Eligible employees are employees who work at least _____ hours per week.

Total number of all eligible employees _____ Total number of enrollment forms enclosed _____

Waiting period: new employees will be eligible on the first day of the month following _____ complete month(s) of continuous employment.

Full-time students will be covered regardless of age unless you select an age (not to be less than age 24).

DENTAL RATES

Single \$ _____ Employee only \$ _____ Employee only \$ _____
Family \$ _____ or Two Party \$ _____ or Employee/Spouse \$ _____
Three or More \$ _____ Employee/Children \$ _____
Employee/Spouse/Children \$ _____

Are employee contributions made under a pre-tax plan? yes no

Your monthly invoice will be available by logging on to Delta Dental’s website. The e-mail address you would like to use so we can notify you that your invoice is ready _____

Delta Dental only accepts payment by electronic funds transfer. A voided check from the account you would like us to withdraw from each month must be attached to this application.

AGENT INFORMATION

Agent name _____ Firm name _____

Address _____

Phone and e-mail _____

Agent signature _____ Date _____

AGREEMENT

The employer agrees to:

1. Pay at least _____% of the single cost as an employee benefit.
2. Coverage will terminate for an employee on the last day of the month in which his employment terminates.
3. This agreement will be in force per the terms of your contract.

By _____ Title _____ Date _____