



Application for Pooled Group Dental Coverage

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 _____

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.

RATES

Program applied for:

_____ 5-Plus

_____ 10-Plus

_____ 10-Plus with Orthodontics

_____ 25-Plus

_____ 25-Plus with Orthodontics

Rates:

Single _____

Family _____

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.

Participation Requirements

- **The employer must pay the full single cost for all eligible employees.**
- **100% enrollment of all full-time employees who have satisfied the eligibility waiting period. Part-time employees may be included only if the employer pays the cost for all eligible part-time employees.**
- **Employees may not change coverage for any reason other than death, divorce or marriage except at open enrollment, January 1.**
- **Terminated employees are covered to the last day of the month in which they cease to be an eligible employee (unless your group has 20 or more employees and is subject to COBRA laws).**
- **New employees are eligible the first of the month after completion of the waiting period.**
- **Rates are guaranteed to December 31 from the effective date of coverage.**

I hereby certify that all of the above information is true and correct. I agree to abide by the guidelines as set forth above. In the event such guidelines are not adhered to, Delta Dental may commence termination procedures.

Signed _____ Title _____

Name _____ Date _____

Agent Information

As the acting representative for the above group, I have to the best of my knowledge and ability complied with the guidelines and underwriting rules listed by DDS in this application.

Agent name _____ Firm name _____

Address _____ City, State and Zip _____

Agent signature _____ Date _____