



Application for Voluntary Group Dental Coverage

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

Fax _____ Nature of business _____

Contact person _____ Phone _____

E-mail address _____

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.

Employer paying _____% of the single cost OR pre-tax dental premium yes _____ no _____

RATES

Plan applied for:

_____ Voluntary I #9050 Single _____

_____ Voluntary II #9060 Family _____

_____ No Minimum Voluntary #9070

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

- **Participation is based on:**
 - Voluntary I #9050 - 35% of eligible employees enrolled (minimum of 3)**
 - Voluntary II #9060 - 50% of eligible employees enrolled (minimum of 10)**
 - No Minimum Voluntary #9070 – no minimum percentage of employees (minimum of 2)**
- **Employers are required to pay 25% of the single cost OR pre-tax dental premium for Voluntary I #9050 and Voluntary II #9060. No employer contribution is required for the No Minimum Voluntary Plan #9070.**
- **New employees are eligible the first of the month after completion of the employer's waiting period.**
- **Rates are guaranteed to December 31 from the effective date of coverage.**
- **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.**

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 _____ Agency name _____

Address _____ City, State and Zip _____

Phone _____ E-mail _____

Agent signature _____ Date _____