



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:

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

Are separate billings required for these companies? ____Yes ____No

EMPLOYEE INFORMATION

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.

Dependent children will be covered to age _____ Full-time students will be covered to age _____

Would you like Delta Dental to take care of employee COBRA paperwork for no extra charge? Yes No

Would you like employee ID cards to be sent to the group address above or to employees at their home?

_____Group _____Home

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

The employer will pay _____% of the single cost as an employee benefit.

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

This agreement will be in force per the terms of your contract.

Signed _____ Title _____

Name _____ Date _____