



## Application for SD Retailers Association Group Dental Coverage

(must be a member of the SD Retailers Association)

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 \_\_\_\_\_

Contact name \_\_\_\_\_ Contact phone \_\_\_\_\_

Street address \_\_\_\_\_ P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_

Fax \_\_\_\_\_

### Employee Information

Total number of 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.

Delta Dental will handle COBRA paperwork for employees at no extra charge unless we are notified  
otherwise.

ID cards will be sent to the employee.

### Rates and Payment

Rates:	8010 & 8012 Plans	8013 & 8015 Plans
Employee	\$ _____	Employee \$ _____
Family	\$ _____	Employee/Spouse \$ _____
		Employee/Children \$ _____
		Family \$ _____

The employer pays \_\_\_\_\_% of the single cost.

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**

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- The employer must be a South Dakota Retailers Association member.
- The employer must pay at least 25% of the single cost for 8010 and 8013 plans and 50% of the single cost for the 8012 and 8015 plans.
- New employees are eligible the first of the month after completion of the waiting period.
- A minimum enrollment of 50% (for 8010 and 8013 plans) and 75% (for 8012 and 8015 plans) of all full-time employees who have satisfied the eligibility waiting period is required. Part-time employees may be included only if the employer pays for eligible part-time employees.
- Employees may not change coverage for any reasons other than death, divorce or marriage except at open enrollment in January.
- Terminated employees are covered to the last day of the month in which they cease to be an eligible employee.
- Rates are guaranteed to December 31.

I certify that all of the above information is true and correct. I agree to abide by the participation requirements as set forth above. In the event such requirements are not adhered to, Delta Dental may terminate this policy.

Signed \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

## **Agent Information**

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As the acting representative for the above group, I have to the best of my knowledge and ability complied with the participation requirements listed above.

Agent name \_\_\_\_\_ Firm name \_\_\_\_\_

Address \_\_\_\_\_ City, State and Zip \_\_\_\_\_

Agent signature \_\_\_\_\_ Date \_\_\_\_\_