

EMPLOYER

APPLICATION & AGREEMENT

Delta Dental PPO (Standard)
Under 50
Non-COSE

Please take a moment to complete this form. We will consider it and any other applicable information, as your application to Delta Dental. Coverage or administration for your group will not start until you receive approval in writing from Delta Dental. Absence of written approval does not imply acceptance. **If you have any questions regarding this application or any of Delta Dental's programs, please feel free to contact your Delta Dental representative. Please note: All eligibility and billing will be handled through Kaiser Permanente.**

Please select one:

- New Kaiser Permanente Group
 Plan change for existing Kaiser Permanente Group

Client Name: _____

Client Contact: _____ **Title:** _____

Client Officer: _____ **Title:** _____

Delta Dental Client Number: 7500

Kaiser Permanente Client Number: _____ *(Delta Dental Subclient Number)*

Please Note: Delta Dental may assign a different Subclient Number

Effective Date: _____ *(Same as medical plan effective date)*

Renewal Date: _____ *(One year from effective date)*

Client Contact Information:

(Note: Delta Dental will not accept a P.O. Box Number as a source mailing address. The company's physical location address must appear on this application.)

Street Address: _____

City _____ **State** _____ **ZIP Code** _____ **County** _____

Telephone _____ **Fax Number** _____

E-Mail Address _____ **Tax Identification Number** _____

Number of Subscribers _____ (Definition of Subscriber: Those individuals eligible according to Kaiser's medical plan guidelines.)

****Employees cannot opt out of the dental plan****

Agreement

The undersigned employer hereby adopts and subscribes to the terms and provisions in the application and to the terms and provisions of the contract of which this application becomes a part.

It is agreed that the employer has 15 days from the date of delivery of the contract to return the contract to Delta Dental's corporate headquarters for a full refund. If the employer exercises this right, the contract will terminate on the effective date as if no coverage or administrative services were ever in force, and all money received will be returned.

This application is subject to approval, refusal, or modification in accordance with Delta Dental's guidelines. Misrepresentation or fraud will cause this application and subsequent contract to be null and void from the start.

The undersigned authorizes Kaiser Permanente to perform all eligibility and billing maintenance on their behalf.

_____ Date of _____, 20 _____, at _____

Print or Type Name of Authorized Client Official

Title

Signature of Authorized Client Official

Date

Print or Type Name of Agent or Delta Dental Representative

Title

Signature of Agent or Delta Dental Representative

Date

For Delta Dental Use Only (Informational):

Billing Address

1001 Lakeside Ave., Suite 1200, Cleveland, OH 44114
Attention: Membership Administration

Contract Type:	Non – Retention
New Employee Waiting Period:	None
Condensed Bill:	Yes
Type of Industry:	N/A
NAICS Code:	00000
Industry Code:	19
Enrollment by Electronic Media:	Yes
Delta Dental Account Executive:	Tom Bartram
Delta Dental Account Service Manager:	Karen Chapman
Underwriter:	Sandy Griggs
Kaiser Permanente Account Manager:	_____
Standard Materials:	Certificate, Summary and Reference Cards
Send Materials to:	Client Contact

COORDINATION OF BENEFITS:

Internal (Spouses in the same client can cover each other):	Yes
External (Spouses in different clients can cover each other):	Yes

Benefit Level Comparison Grid

The following Benefit Comparison Grid is a brief overview of the levels of coverage offered within the Delta Dental PPO (Standard) through Kaiser Permanente. The percentages listed are based on using a Delta Dental PPO (PPO) dentist. In the event that you seek treatment from a non-PPO dentist, you may be responsible for more than the percentage indicated.

<u>Coverage Level</u>	<u>PREVENTIVE</u>	<u>BASIC</u>	<u>STANDARD</u>	<u>HIGH</u>
Select level of coverage for your group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Class I Benefits</u>				
Diagnostic and Preventive Services	40%	50%	100%	100%
Emergency Palliative Treatment	40%	50%	100%	100%
Sealants	0%	50%	100%	100%
Radiographs	40%	50%	100%	100%
<u>Class II Benefits</u>				
Oral Surgery Services	0%	15%	50%	80%
Endodontic Services	0%	15%	50%	80%
Periodontic Services	0%	15%	50%	80%
Relines and Repairs	0%	15%	50%	80%
Minor Restorative Services	0%	15%	50%	80%
<u>Class III Benefits</u>				
Prosthodontic Services	0%	15%	30%	50%
Major Restorative Services	0%	15%	30%	50%
<u>Class IV Benefits</u>				
Orthodontic Services	0%	0%	0%	40%
<u>Maximum Benefit per person</u>				
Per Benefit Year for Class I, II, III	\$250	\$600	\$600	\$1,000
Lifetime Maximum for Class IV	\$0	\$0	\$0	\$1,000

2010 MONTHLY RATES (5 TIER)

Employee Only	\$1.44	\$4.93	\$18.91	\$32.20
Employee and Spouse	\$2.86	\$9.70	\$36.79	\$62.79
Employee and Child	\$3.96	\$9.50	\$38.55	\$69.68
Employee and Children	\$4.98	\$11.29	\$46.44	\$84.76
Employee, Spouse, and Children	\$6.38	\$16.05	\$64.34	\$115.37

An Equal Opportunity Employer

<u>Delta Dental Use Only</u>	<u>HCC</u>	<u>Admin.</u>
Preventive	061	24.83%
All Others	301	24.83%

Rule Package – Posterior resins payable

HIPAA GROUP HEALTH PLAN CERTIFICATION

The _____ Group Health Plan ("Plan"), through its fiduciary, does hereby certify to the following:

1. That the Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
2. That the Plan documents you distribute to employees informing them about their benefits **or** the Plan documents you are legally required to maintain for your employee benefits plans have been amended, as required by 45 CFR 164.504(f) of HIPAA, to incorporate the following provisions and you, as the Plan Sponsor, agreed to:
 - a. Not use or further disclose health information protected under HIPAA ("PHI") other than as permitted or required by the plan documents or as required by law;
 - b. Ensure that any agents, including subcontractors, to whom you provide PHI agree to the same restrictions and conditions that apply to you with respect to such information;
 - c. Not use or disclose PHI for employment-related actions and decisions;
 - d. Not use or disclose PHI in connection with any other benefit or employee benefit plan;
 - e. Report to Plan's designee any PHI use or disclosure that you become aware of that is inconsistent with the uses or disclosures provided for;
 - f. Make PHI available to an individual based on HIPAA's access requirements;
 - g. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
 - h. Make available the information required to provide an accounting of disclosures;
 - i. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U. S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
 - j. Ensure that adequate separation between the Plan and the Plan Sponsor is established as required by HIPAA [45 CFR 164.504(f)(2)(iii)]; and
 - k. If feasible, return or destroy all PHI received from the Plan that you, as the Plan Sponsor, still maintain in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, you will limit further uses and disclosures to those purposes that make the return or destruction infeasible.
3. The undersigned further certifies that he or she has the authority to sign on behalf of the Plan.

Printed Name of Group

Delta Dental Group Number(s)

Signature of Plan Fiduciary Representative

Date

OR We decline to sign this Group Health Plan Certification and will not create, maintain, receive, or access PHI for our group members.

Printed Name of Plan Fiduciary Representative

Delta Dental Group Number(s)

Signature of Group Representative

Date