

<b>GROUP INFORMATION</b>			
Group name _____			
4-digit SIC Code _____		Industry Type _____	
Contact person _____		Telephone number _____	Fax number _____
Street address _____		City _____	State _____ ZIP code _____
Billing address (if different) _____		City _____	State _____ ZIP code _____
Will your group offer dual choice to its employees (choice of more than one dental program?) <input type="checkbox"/> No <input type="checkbox"/> Yes. Delta is carrier for both programs. <input type="checkbox"/> Yes. Our carriers are Delta and: _____		Will this Delta program replace existing dental coverage your group currently has through another dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, name of previous carrier: _____	
Proposed effective date of coverage _____	Signature of company officer _____		Date _____
Name (print) _____		Title (print) _____	

**DELTAPREMIER or DPO Program for businesses with 5-99 employees (Classic Program)**

**Program design (Check one)**

<input type="checkbox"/> Premier 50/50/50/50, Plan 1000	<input type="checkbox"/> Premier 100/80/50/50, Plan 1000	<input type="checkbox"/> DPO, Plan 1000
<input type="checkbox"/> Premier 50/50/50/50, Plan 1500	<input type="checkbox"/> Premier 100/80/50/50, Plan 1500	<input type="checkbox"/> DPO, Plan 1500

Child ortho (Orthodontic Option requires minimum 10 enrollees in DeltaPremier or DeltaPreferred Option)

**DELTAPREMIER or DPO Program for businesses with 50-99 employees (Options Program)**

Check one:

Services	DeltaPremier	DPO 1		DPO 2		DPO 3	
	UCR	In-Network DPO Fee Schedule	Out-of-Network UCR	In-Network DPO Fee Schedule	Out-of-Network UCR	In-Network DPO Fee Schedule	Out-of-Network UCR
Diag & Prev	100%	100%	100%	100%	80%	100%	100%
Basic	80%	90%	80%	80%	80%	80%	80%
Crowns and Cast Restorations	50%	60%	50%	50%	50%	50%	50%
Prosthodontics	50%	60%	50%	50%	50%	50%	50%
Deductible	\$50/\$150	\$50/\$150		\$50/\$150		\$40/\$120	\$50/\$150

**SELECT OPTIONS — CHOOSE ALL THAT APPLY**  
**IF STANDARD OPTION IS CHOSEN, PLEASE LEAVE BLANK**

Deductible (Standard: \$50 per person/\$150 family maximum) <input type="checkbox"/> \$25/\$75 (except for DPO3) Annual Maximum (Standard: \$1,000 per person, per calendar year) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 Orthodontia — 50% copayment (Standard: No orthodontic services) <input type="checkbox"/> Children only <input type="checkbox"/> Adult & Children Orthodontic lifetime maximum (Choose one if orthodontia is selected) <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Endodontic/Periodontic Coverage (Standard: Covered as Basic) <input type="checkbox"/> Cover as Major Orthodontic Option requires minimum 10 enrollees in DeltaPremier or DeltaPreferred Option.	<p style="text-align: center;"><b>Vision By EyeMed</b></p> <input type="checkbox"/> Standard <input type="checkbox"/> Enhanced <input type="checkbox"/> No Vision
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**Census Data (DeltaPremier and DPO programs)**

Total number of eligible employees: _____	<b>Employer Contribution</b>	*(Minimum 80% employee and 50% dependent participation required; 100% contribution requires 100% employee and dependent participation)
Total number of enrollees: _____	Employees _____% Minimum 75%*	
	Dependents _____% *	

Dental Distribution by dependency status/dues		3 Tier		Dental Rates	Vision Rates	Total
		No. of enrollees				
One party	_____	x	_____	_____	=	_____
Two party	_____	x	_____	_____	=	_____
Three party +	_____	x	_____	_____	=	_____
Total						_____

Vision Distribution by dependency status/dues		4 Tier		Dental Rates	Vision Rates	Total
		No. of enrollees				
One party	_____	x	_____	_____	=	_____
Two party	_____	x	_____	_____	=	_____
Three party +	_____	x	_____	_____	=	_____
Total						_____

## Census Data (DeltaCare program)

Complete the following information if your group is applying for DELTACARE (Delta's HMO administered by Delta affiliate PMI)

Total number of eligible employees: \_\_\_\_\_ Total number of enrollees: \_\_\_\_\_ (This program requires 5 enrollees minimum)

### Program design (Check one)

- 10A  
 11A  
 12A

### Employer Contribution (Check one)

- Option A, Non-voluntary (at least 75% employer-paid)  
 Option B, Voluntary dependents  
 Option C, Voluntary (100% employee-paid)

### Distribution by dependency status/dues

	No. of enrollees	Dental Rates	Vision Rates	Total
One party	_____ x	_____	_____	= _____
Two party	_____ x	_____	_____	= _____
Three party +	_____ x	_____	_____	= _____
Total				_____

### Employee eligibility period (check one):

- Standard: First of month, following 90 days of employment  
 Custom: As mirrors our group medical plan:  
 1. First of the month following date of hire  
 2. Date of hire (group must pay dues for entire month of coverage regardless of date of hire)  
 3. First of the month, following \_\_\_\_\_ days of employment (minimum of 30 days)

### Domestic Partner Coverage

- No  Yes  
 Check one:  
 Domestic partner only  
 Domestic partner and children of domestic partner

## Submit to your broker

### DeltaPremier and DeltaPreferred Option

- 1) this completed application
- 2) completed Enrollment/Change forms for each eligible employee or completed Enrollment/List Forms for all enrollees
- 3) Most recent FICA or SDI Tax Filing (DE-6)
- 4) Check for your first month's dues (dental and vision) made payable to **Delta Dental**

### DeltaCare

- 1) this completed application
- 2) completed Enrollment forms for each enrollee
- 3) a check for your first month's dues (dental and vision) made payable to **Delta Dental**

IT IS AGREED THAT DUES AND A CURRENT ELIGIBILITY LIST WILL BE SUBMITTED TO DELTA'S DESIGNATED ADMINISTRATOR BY THE TWENTY-FIFTH OF THE MONTH PRIOR TO THE COVERAGE MONTH.

The program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of PMI and/or Delta Dental. It is understood and agreed that this application be made a part of such agreement.

## Broker Information

Broker's name	Telephone number	Fax number	
Company name			
Mailing address	City	State	ZIP code
Broker's signature	Date		
(Please furnish one) <input type="checkbox"/> Social Security number:	<input type="checkbox"/> TIN number:	Company is Inc. <input type="checkbox"/> Yes <input type="checkbox"/> No	

## General Agent Information

GA Company Name	DENTAL ONLY <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2
GA Sales Representative	
Delta Account Executive	