



APPLICATION FOR A DENTAL CONTRACT

Delta Dental of New York
 Administrative Offices
 One Delta Drive, Mechanicsburg, PA 17055
 (800) 932-0783 TTY/TDD (888)373-3582

APPLICANT INFORMATION	Group Number: _____ Division(s): PPO plus Premier - Plan 3		
Name of Applicant: _____		Nature of Business: _____	
Address: _____			
City: _____	State: _____	Zip: _____	County: _____

CONTRACT TERM: From: _____ Through: _____ Contract Length: <u>2 Year</u>	<input checked="" type="checkbox"/> DUSA
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PROGRAM TYPE: <input type="checkbox"/> Delta Dental Premier <input type="checkbox"/> DeltaCare USA <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> Flexible Dual Choice: <input checked="" type="checkbox"/> Delta Dental PPO Plus Premier <input type="checkbox"/> Annual <input type="checkbox"/> Other: _____ <input type="checkbox"/> Monthly	DEPENDENT COVERAGE: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"> X Spouse X Children to age 26, regardless of full-time student or marital status <input type="checkbox"/> Ortho to age </td> <td style="width: 40%;"> <input type="checkbox"/> Domestic Partners <input type="checkbox"/> Domestic Partner Dependents </td> </tr> </table>	X Spouse X Children to age 26, regardless of full-time student or marital status <input type="checkbox"/> Ortho to age	<input type="checkbox"/> Domestic Partners <input type="checkbox"/> Domestic Partner Dependents
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FREQUENCY LIMITATIONS: Exams: 2 in any 12 Month period Prophylaxes: 2 in any 12 Month period Fluoride: 2 in any 12 Month period Bitewing x-rays: 2 in any 12 Month period	COORDINATION OF BENEFITS: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Non-Duplication <input type="checkbox"/> No Internal COB <input checked="" type="checkbox"/> Primary for Impactions	BENEFITS TURNOVER PERIOD: <input checked="" type="checkbox"/> Calendar Year <input type="checkbox"/> Contract Year (to)
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UNIQUE LIMITATIONS OR EXCLUSIONS (Attach additional page if necessary)
Previous Group Dental Coverage? If so, please list dates and name of previous carrier.

SERVICES	PPO	Premier	Non-Par	SERVICES	PPO	Premier	Non-Par
Diagnostic	100 %	100 %	100 %	Orthodontics	50%	50%	50%
Preventive	100 %	100 %	100 %	Posterior Composites	80 %	80 %	80 %
Basic Restorative	80 %	80 %	80 %				
Major Restorative	50 %	50 %	50 %				
Oral Surgery	80 %	80 %	80 %				
Endodontics	80 %	80 %	80 %				
Periodontics (<i>Surgical</i>)	80 %	80 %	80 %				
Periodontics (<i>Non-Surgical</i>)	80 %	80 %	80 %				
Prosthodontics	50 %	50 %	50 %				
Sealants	100 %	100 %	100 %				
TMJ	50 %	50 %	50 %				

DEDUCTIBLE(S)				MAXIMUM(S)				
	PPO	Premier	Non-Par	Based on:		Annual Max		Based on:
Per Enrollee	\$ 50	\$ 50	\$ 50	Calendar year	Per Enrollee	\$ 1000		Calendar Year
Per Family	\$150	\$ 150	\$ 150	Calendar year	Per Family	N/A		N/A
Orthodontics	N/A	N/A	N/A		Orthodontics	\$1000		Lifetime
Services Exempt from the Deductible:				<input checked="" type="checkbox"/> Diagnostic & Preventive <input checked="" type="checkbox"/> Sealants <input checked="" type="checkbox"/> Orthodontics <input type="checkbox"/> Other: _____				

CENSUS INFORMATION:
 Total Number of Employees: _____
 Number of Employees Eligible: _____
 Number of Single: _____
 Number of Two-Party: _____
 Number of Family: _____

EMPLOYER CONTRIBUTION:
 _____ Employees
 _____ Dependents

REQUIRED PARTICIPATION:
 A minimum of 5 employees or 50 percent of all eligible employees, whichever is fewer.

RATES: Monthly per Employee Type:
 1st Year
 Single: \$ 39.81 \$ _____
 Two-Party: \$ 73.67 \$ _____
 Family: \$ 110.94 \$ _____

RATING METHOD:
 Prospective
 Cost Plus
 Retention
 ASO/ERISA
 Prefund: \$ _____

ADMINISTRATION OR RETENTION FEE:
 % of claims % of premium
 \$ _____ Per employee per month

Settlement: Claims: _____ by _____
 Fee: \$ _____ by _____

ELIGIBILITY INFORMATION:
New Hire Eligibility:
Additions: Standard
Terminations: Standard

BROKER / CONSULTANT INFORMATION (if applicable)

Company Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Contact Person: _____ Title: _____
 E-mail Address: _____ Phone: () - _____ Fax: () - _____
 Commission Amount: _____ Commission Payable To: _____

SPECIAL REQUESTS (Attach additional page if necessary)

Medical Carrier _____
 Application is herewith made for a dental service contract from Delta Dental of New York, Inc. (Delta). It is understood that this Application is offered as an inducement for issuance of a dental service contract by Delta. Such contract will be based exclusively on the information given to or acquired by Delta from this Application. To that end, the signer of the Application declares that he/she has read the statements and answers above and that to the best of his/her knowledge that the answers are true. No waiver or modification of the Application shall be accepted unless in writing and signed by an authorized officer of Applicant. It is understood that acceptance of this Application shall only be by delivery to Applicant of a dental service contract duly signed by the President of Delta. Applicant understands that, regardless of the effective date above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta with Protected Health Information ("PHI") for the proper implementation, administration and management of the group dental contract for which the Applicant is applying. Delta agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental service contract or as permitted or required by law. Delta and Applicant shall comply with all applicable federal and state laws and regulations relating to administrative simplification, security, and privacy of PHI, including the terms of any business associate agreement/addendum that may be required as part of the group dental service contract to be executed between the Applicant and Delta.

Dated on _____ Name of Applicant _____
 By _____
 Witness _____
 Soliciting Agent _____

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.