Please take a moment to complete this form. We will consider it, along with your group's experience, enrollment data, and any other applicable information, when setting up your account with Delta Dental.

Absence of written approval does not imply acceptance. Depending on the plan you choose, there may be minimum enrollment requirements.

If you have any questions regarding this form or any of Delta Dental's programs, please feel free to contact your Delta Dental representative.

CLIENT INFORMATION FORM

(PEDIATRIC ONLY)

Coverage or administration for your group will not start until you receive approval in writing from Delta Dental.

Client Name (as it will appear on the contract): _____

Plan: ☐ Michigan ☐ Ohio ☐ Indiana

Client Tax Identification/EIN #: _____

Effective Date: _____ When does this contract first renew/renewal date: _____

Physical Location *: _____

(*PO Box addresses are NOT acceptable for the client location)

City: _____ State: _____ ZIP Code: _____ County: _____

CLIENT CONTACT INFORMATION ☐ Same as Client Physical Location

Only one contact name can be selected per Contact Type

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ All ☒ General ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials ☐ Overage Dependent

Telephone: (_____) _____ Ext: _____ Cell: (_____) _____

Fax: (_____) _____ Email Address: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

ADDITIONAL CLIENT CONTACT INFORMATION ☐ Same as Client Physical Location

Only if additional contacts are required

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____

Contact Type: ☐ Renewal ☐ Billing ☐ Mailing ☐ Materials ☐ Overage Dependent

Telephone: (_____) _____ Ext: _____ Cell: (_____) _____

Fax: (_____) _____ Email Address: _____

Address: _____

City: _____ State: _____

ZIP Code: _____

CLIENT INFORMATION

Notes:

CLIENT - BENEFIT MANAGER TOOLKIT REGISTRATION

Note: BMT Administrator must be an employee of the client.

Update your group's eligibility online, real time, using our Web-based tool, Benefit Manager Toolkit (BMT). With BMT you can enroll a new member, update existing members, view eligibility and your benefits, print dentist directories, and access flexible and convenient reports (if your group qualifies for reports). In addition, **your monthly invoice and other billing details are provided to you through BMT**.

Select one individual within your company to be your Client Administrator and complete the information below. This administrator will be able to create and maintain your accounts as well as create BMT user accounts for additional individuals within your company. Delta Dental will send your administrator an email with registration information and additional instructions.

Administrator Name: _____ Title: _____

Email: _____ Phone Number: _____

AGENT/AGENCY - BENEFIT MANAGER TOOLKIT AUTHORIZATION

I **authorize** that the assigned Agent/Agency (including General Agents) requires access to the benefit manager toolkit as indicated.

Please indicate the type of access for the assigned Agent/Agency.

Type of Access:

☐ UPDATE AND VIEW ELIGIBILITY ☐ NO AGENT ACCESS

☐ VIEW ELIGIBILITY ONLY

☐ BILLING DETAILS

☐ CLIENT KNOWLEDGE*

☐ CLAIMS DETAIL REPORTS-ASO*

**Client Knowledge and Claims Detail Reports may not be available to your group*
***Please note: default access is Billing and Update and View Eligibility.*

Note: The Agent/Agency is responsible for the registration and creation of their BMT account(s).

PRIOR CARRIER INFORMATION

☐ Prior Carrier? *(If checked, please provide copy of invoice or benefit summary from prior carrier)*

Name of Prior Carrier: _____

BILLING CONFIGURATION

Bill Type (How would you like to receive your bill?): ☐ Mail ☐ Electronic Only (via BMT)

COORDINATION OF BENEFITS(COB) PROCESSING INFORMATION

☐ Support Internal COB (Spouses with the same employer can cover each other):

☐ Support External COB (Spouses with different employers can cover each other):

Payment Option Type: ☒ Standard

EMPLOYEE PARTICIPATION VERIFICATION

*Please confirm the percentage that the **employer** contributes for employees and dependents:*

_____% **Employer** Contribution for Employee
_____% **Employer** Contribution for Dependents

0% Minimum Participation Required

DELTA DENTAL®

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 Plan Fiduciary Representative

_____ _____
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

_____ _____
Signature of Plan Fiduciary Representative Date

Please fill in the name of your group health plan, sign and date this Certification, and return one original to Delta Dental, P.O. Box 30416, Lansing, MI 48909.

FOR AGENTS ONLY

Primary Agent Name: _____

Social Security Number: _____

Primary Agency Name: _____

TIN: _____

Checks to: ☐ Agency ☐ Agent

YOUR SOCIAL SECURITY NUMBER IS REQUIRED BY THE STATE FOR APPOINTMENT.

Address: _____

City: _____ State: _____ ZIP Code: _____

Is there more than one Agent? ☐ (Attach complete agent information and complete second page)

If yes, what is the percentage of the total commission for each agent?

Primary Agent: _____ %

Secondary Agent: _____ %

STANDARD COMMISSION SCHEDULE	
GROUP SIZE	STANDARD PERCENT OF PREMIUM OR ADMINISTRATIVE FEES & CLAIMS PAID
1 to 24 subscribers	10.00%
25 to 49 subscribers	7.75%
50 to 99 subscribers	6.25%
100 to 199 subscribers	4.75%

☐ Standard (displayed above) ☐ Flat _____%

Start Date: _____

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Delta Dental in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Delta Dental. This requirement is a condition to eligibility for receiving compensation under Delta Dental's agency/agent compensation program as described in Delta Dental's Agency/Agent Agreement. Delta Dental will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this form I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Delta Dental related to the client's purchase of a Delta Dental benefit plan.

Agent's Signature: _____ Date: _____

FOR AGENTS ONLY

☐ Secondary Agent ☐ General Agent

Secondary Agent Name: _____

Social Security Number: _____

Secondary Agency Name: _____

TIN: _____

Checks to: ☐ Agency ☐ Agent

YOUR SOCIAL SECURITY NUMBER IS REQUIRED BY THE STATE FOR APPOINTMENT.

Address: _____

City: _____ State: _____ ZIP Code: _____

Commission Type: ☐ Flat ☐ Standard

Commission Start Date: _____

Commission Percent: _____ %

Agency or Agent shall disclose in writing to the client, in advance of the purchase of business, the nature of any compensation the Agency or Agent will or may receive or be eligible to receive from Delta Dental in connection with the placement or servicing of the client's business, as well as the nature of any other material business relationship between the Agency or Agent and Delta Dental. This requirement is a condition to eligibility for receiving compensation under Delta Dental's agency/agent compensation program as described in Delta Dental's Agency/Agent Agreement. Delta Dental will report to Agent's or Agency's designated clients all compensation paid to Agency or Agent for work performed on behalf of such clients. By signing this form I warrant and represent that I have made full disclosure to the client of any and all compensation I may receive from Delta Dental related to the client's purchase of a Delta Dental benefit plan.

Agent's Signature: _____ Date: _____