

**APPLICANT INFORMATION**

Name of Applicant:	Fed. ID/TIN:		
Contact:	Phone:		
Email:	Fax:		
Address:			
City:	State:	ZIP Code:	County:
Industry Type:	SIC:		
Billing Address, if different:			
Billing Contact:		Phone:	Fax:
Billing Email:			
Situs State: Connecticut	Group Type: Employer	Contract Type: Non Retention	Length of Contract: One Year
Proposed Effective Date:	Open Enrollment Month (if different from renewal date):		
Recipient of Electronic Documents and Notices: <input type="checkbox"/> Applicant <input type="checkbox"/> Other (provide name and email, address or fax number):			

**ELECTRONIC DELIVERY OF DOCUMENTS TERMS AND CONDITIONS**

Delta Dental strives to be a green enterprise. As part of Delta Dental's green initiatives, we offer you the opportunity to have your contract-related documents, including those that you will distribute to your group enrollees, made available to you electronically. If you choose to have your contract(s)-related documents made available to you electronically, the terms and conditions below apply.

1. **Communication Methods:** All communications that we provide to you in electronic form will be provided either (1) by accessing Delta Dental's website with your username and password or (2) via email. Documents sent to you through one of these two electronic methods will be considered delivered and received unless there is an indication that the email address provided is invalid. All written documents delivered to you electronically will be considered "in writing." You should print or download for your records a copy of all electronic communications, this electronic document disclosure, and any other document that is important to you.
2. **Types of Documents that Will Be Electronically Communicated:** Documents available electronically include but are not limited to: your contract(s), Benefits Summary Booklet(s) for your enrollees, and your notifications, including the HIPAA Notice of Privacy Practices.
3. **How to Withdraw Consent:** You may withdraw your consent to transact business and receive notifications electronically by contacting Delta Dental. We may treat your provision of an invalid email address or the subsequent malfunction of a previously valid address as a withdrawal of your consent to receive electronic communications. A withdrawal of your consent to transact business and receive notifications electronically will be effective only after we have had a reasonable period of time to process the request.
4. **How to Update Your Records:** It is your responsibility to provide us with a true, accurate and complete email address, and to maintain and update promptly any changes to this information. You can update your information by contacting Delta Dental's designated administrator.
5. **Hardware and Software Requirements:** In order to access, view, sign, and retain electronic documents that we make available to you, you must:
  - Have a device that will connect to the internet, have access to an email account, and have access to an internet browser.
  - Access to Adobe products will not be required to electronically sign forms but may be necessary to view, download, or print documents.
  - Be able to view the disclosures or notifications on your device.
  - Have sufficient storage capacity on your computer's hard drive or other data storage unit.

We will update you if there are any changes to the hardware or software requirements that could impact receiving or signing electronic documents.

**Applicant has reviewed the Electronic Delivery Terms and Conditions above and consents to have contract-related documents and notifications, including the HIPAA Notice of Privacy Practices, provided electronically.**

**RESET**

Applicant accepted on: \_\_\_\_\_  
Delta Dental Group #: \_\_\_\_\_

Select Dental Benefit Design

Plan	<input type="checkbox"/> PPO		<input type="checkbox"/> PPO Plus Premier	
	Groups 2-9	Groups 10-50	Groups 2-9	Groups 10-50
<input type="checkbox"/> Plan 1	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750	<input type="checkbox"/> \$750/\$500 <input type="checkbox"/> \$1,000/\$750	<input type="checkbox"/> \$750/\$500 <input type="checkbox"/> \$1,000/\$750
<input type="checkbox"/> Plan 2	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,250/\$1,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,250/\$1,000
<input type="checkbox"/> Plan 3	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 4	<i>Plan not offered</i>	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 4-Enhanced Ortho 1500	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 4-Maximum Ortho 2000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	<input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 5	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 6	<i>Plan not offered</i>	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 6 Enhanced Ortho 1500	<i>Plan not offered</i>	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan 6 Maximum Ortho 2000	<i>Plan not offered</i>	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	Deductible <input type="checkbox"/> \$50/\$150 <input type="checkbox"/> \$75/\$225 CYM <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$5,000/\$4,500

Select Dental Benefit Design

Plan	<input type="checkbox"/> PPO		<input type="checkbox"/> PPO Plus Premier	
	Groups 2-9	Groups 10-50	Groups 2-9	Groups 10-50
<input type="checkbox"/> Plan 7	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500
<input type="checkbox"/> Plan 8	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan PPO Plus Premier 90	<i>Plan not offered</i>	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000	<input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan A	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500
<input type="checkbox"/> Plan B	<i>Plan not offered</i>	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500
<input type="checkbox"/> Plan B Enhanced Ortho 1500	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500
<input type="checkbox"/> Plan B Maximum Ortho 2000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<i>Plan not offered</i>	<input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500
<input type="checkbox"/> Plan C	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan D	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan D Enhanced Ortho 1500	<i>Plan not offered</i>	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500

Select Dental Benefit Design

Plan	<input type="checkbox"/> PPO		<input type="checkbox"/> PPO Plus Premier	
	Groups 2-9	Groups 10-50	Groups 2-9	Groups 10-50
<input type="checkbox"/> Plan D Maximum Ortho 2000	<i>Plan not offered</i>	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<i>Plan not offered</i>	<input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan V1	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750	<i>Plan not offered</i>	<input type="checkbox"/> \$500/\$500 <input type="checkbox"/> \$750/\$500
<input type="checkbox"/> Plan V2	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500
<input type="checkbox"/> Plan V3	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500
<input type="checkbox"/> Plan V4	<i>Plan not offered</i>	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500
<input type="checkbox"/> Plan V5	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500
<input type="checkbox"/> Plan V6	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,250/\$1,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,250/\$1,000
<input type="checkbox"/> Plan PPO Plus Premier V90	<i>Plan not offered</i>	<i>Plan not offered</i>	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000	<input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500
<input type="checkbox"/> Plan VA	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500
<input type="checkbox"/> Plan VC	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,000/\$750 <input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$3,000/\$2,500	<input type="checkbox"/> \$1,500/\$1,000 <input type="checkbox"/> \$2,000/\$1,500 <input type="checkbox"/> \$2,500/\$2,000 <input type="checkbox"/> \$3,000/\$2,500 <input type="checkbox"/> \$5,000/\$4,500

**ELIGIBILITY INFORMATION****Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):**

# of Eligible Employees:	# of Enrolled Employees:	# of Employees on Continuation:	Prior Carrier:		
Eligible Individuals (check applicable boxes):		<input type="checkbox"/> Eligible Employees	All employees working hours		
Eligible Dependents (check applicable boxes):		<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Other
Eligible Requirement (check one):					
<input type="checkbox"/> Date of hire		<input type="checkbox"/> First of the month following date of hire		<input type="checkbox"/> First of the month following	days of employment

**ERISA INFORMATION**ERISA Applies  Yes  NoPlan details same as Applicant?  Yes  No; if "no" then provide information below:

Plan Sponsor:

Plan Sponsor's Employer I.D.:

Plan Administrator:

Agent for Service of Legal Process:

Plan Number:

**DENTAL FUNDING****Employer Contribution and Participation Requirement (check one):**

<input type="checkbox"/> 50%-99% (75% of eligible employees, 50% of eligible dependents)	<input type="checkbox"/> 0% <input type="checkbox"/> 1%-49.9% (Voluntary Plans Only) (25% of eligible employees)	<input type="checkbox"/> 100% (All eligible employees)
For groups with 10 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 10 or more eligible employees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 10 or more eligible employees: All eligible employees must enroll.
For groups with 2-9 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 2-9 primary enrollees: Enrollment may not be less than the greater of the percentage listed above or 2 primary enrollees.	For groups with 2-9 primary enrollees: All eligible employees must enroll.

Note: Refer to Small Business Program brochure for specific plan information and underwriting guidelines.

**MONTHLY RATES**

	Rates		# of Primary Enrollees	Total
<b>3 Tier</b>				
EE Only	\$	x		= \$
EE+ 1	\$	x		= \$
EE + Family	\$	x		= \$
			<b>TOTAL</b>	\$

## Select Vision Benefit Design

- DeltaVision - Essential
- DeltaVision - Brilliance
- DeltaVision - Premium
- DeltaVision - Platinum

### ELIGIBILITY INFORMATION

**Census Data (fill in the total # of primary employees for each of the applicable boxes, listed below):**

# of Eligible Employees:	# of Enrolled Employees:	# of Employees on Continuation:	Prior Carrier:
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Eligible Individuals (check applicable boxes):  Eligible Employees All employees working \_\_\_\_\_ hours

Eligible Dependents (check applicable boxes):  Spouse  Children  Domestic Partner  Other

Eligible Requirement (check one):

Date of hire  First of the month following date of hire  First of the month following \_\_\_\_\_ days of employment

### ERISA INFORMATION

ERISA Applies  Yes  No

Plan details same as Applicant?  Yes  No; if “no” then provide information below:

Plan Sponsor:

Plan Sponsor's Employer I.D.:

Plan Administrator:

Agent for Service of Legal Process:

Plan Number:

### VISION FUNDING

**Employer Contribution and Participation Requirement (check one):**

<input type="checkbox"/> 50%-99%	<input type="checkbox"/> 0% (Voluntary Plans Only)	<input type="checkbox"/> 1%-49.9%	<input type="checkbox"/> 100% (All eligible employees)
For groups with 10 or more eligible employees: Enrollment may not be less than 25% of eligible employees.	For groups with 10 or more eligible employees: Enrollment may not be less than 25% of eligible employees.	For groups with 2-9 primary enrollees: Enrollment may not be less than 2 primary enrollees.	For groups with 10 or more eligible employees: All eligible employees must enroll.
For groups with 2-9 primary enrollees: Enrollment may not be less than 2 primary enrollees.	For groups with 2-9 primary enrollees: Enrollment may not be less than 2 primary enrollees.		For groups with 2-9 primary enrollees: All eligible employees must enroll.

### MONTHLY RATES

	Rates	#Primary Enrollees	Total
<b>3 Tier</b>			
EE Only	\$ _____	x _____	= \$ _____
EE + 1	\$ _____	x _____	= \$ _____
EE + Family	\$ _____	x _____	= \$ _____
<b>TOTAL</b>			\$ _____

**BROKER/AGENT INFORMATION**

Broker/Agent Name:	State Broker License Number:		
Contact Phone:	Contact Email:	Fax:	
Company Name:	SSN/TIN:		
Commission Mailing Address:	City:	State:	ZIP Code:
Commission(s):	Renewal Contact Name and Email address:		
Broker/Agent Signature:	Date:		

**GENERAL AGENT INFORMATION**

General Agent Name:	State Agent License Number:		
Contact Phone:	Contact Email:	Fax:	
Company Name:	SSN/TIN:		
Commission Mailing Address:	City:	State:	ZIP Code:
Commission(s):	Renewal Contact Name and Email address:		
General Agent Signature:	Date:		

Application is herewith made for a dental and/or vision insurance contract from Delta Dental of Connecticut, Inc. ("Delta Dental"). Applicant understands and agrees that any variance to the underwriting criteria for this contract must be approved by Delta Dental prior to acceptance of the application. Applicant understands and agrees that, regardless of the proposed effective date that appears in the Applicant Information section above, unless and until 1) this Application is executed by a duly authorized officer of Applicant and returned to Delta Dental and is accepted, 2) the premium is paid, and 3) enrollment procedures are completed, no claims will be paid for Enrollees under the contract. It is understood that this Application is offered as an inducement for issuance of a dental benefit contract by Delta Dental. Such contract will be based exclusively on the information given to or acquired by Delta Dental from this Application and the terms of said contract will be issued separately. The contract will be deemed accepted and approved based on the Applicant's payment of premium after delivery of the contract. 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.

This plan shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may void or result in cancellation or termination of contract and the ability of the applicant and its covered members to receive benefits if, had the true facts been known to Delta Dental, we would not in good faith have issued the contract or issued the contract at the same premium rate. ***Applicant agrees that premiums and current eligibility list will be submitted to Delta Dental by the 25<sup>th</sup> of the month prior to the coverage month.***

Applicant agrees that it shall be responsible for administering continuation of coverage for eligible employees and/or dependents, including responsibility for providing all required notifications, determining eligibility based on qualifying events, submitting individual enrollment forms to Delta Dental, collecting premiums, and informing Delta Dental when the employee is no longer eligible for continuation of coverage.

Except as otherwise limited by the Health Insurance Portability Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Delta Dental's designated administrator with Protected Health Information ("PHI") for the proper implementation, administration, and management of the group contract for which the Applicant is applying. Delta Dental agrees that the PHI will be held confidential and used or further disclosed only to administer the group plan as described in the group insurance contract or as permitted or required by law. Delta Dental 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 benefit contract to be executed between the Applicant and Delta Dental.

This contract does not include coverage of pediatric dental or vision services that meet essential health benefit requirements of the federal Patient Protection and Affordable Care Act or similar provision of state law.

***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 and subjects such person to criminal and civil penalties.***

Executed this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_, for the Applicant at: \_\_\_\_\_ (City and State)

By: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Print Name and Title)

Delta Dental Authorized Signature: \_\_\_\_\_

(Barry Petruzzi, Vice-President, Underwriting & Actuarial)