HIPAA BUSINESS ASSOCIATE ADDENDUM: GROUP HEALTH PLAN

This HIPAA Business Associate Addendum ("Business Associate Addendum") supplements and is/will be made a part of the group dental contract ("Contract") by and between ("Sponsor/Contractholder") on behalf of the group health plan and Delta Dental Insurance Company ("Delta Dental"). This Business Associate Addendum is effective on the later of April 14, 2003 or the effective date of the Contract.

RECITALS

Whereas, the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and related regulations require that contracts between covered entities and entities known as business associates comply with enumerated standards and requirements;

Whereas, the Sponsor/Contractholder executes this Business Associate Addendum on behalf of the Group Health Plan;

Whereas, Delta Dental's administration of the group dental program for the Sponsor/Contractholder makes Delta Dental a business associate of the Group Health Plan as described or defined under HIPAA;

Whereas, the purpose of this Business Associate Addendum is to satisfy the HIPAA standards and requirements;

Now therefore, in consideration of the mutual promises below, the Sponsor/Contractholder, the Group Health Plan and Delta Dental agree as follows:

SECTION 1 - DEFINITIONS

1.1 "HIPAA" shall mean the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and related regulations, Title 45 Parts 160 and 164 of the Code of Federal Regulations, as amended from time to time.

1.2 "Protected Health Information" (PHI) shall have the same meaning as defined in HIPAA and shall apply to those individuals who are eligible and/or enrolled in the Group Health Plan's dental benefit program administered by Delta Dental.

1.3 Terms used, but not otherwise defined, in this Business Associate Addendum shall have the same meaning as those terms have in HIPAA.

SECTION 2 - BUSINESS ASSOCIATE AGREEMENT

2.1 The provisions of this Section 2 control over any provision in the Contract that conflicts with this Section 2.

2.2 <u>Permitted Uses and Disclosures.</u>

a. Delta Dental shall use and/or disclose PHI received, created or maintained by Delta Dental in accordance with the uses and disclosures described in Exhibit A.

b. Delta Dental shall not use or further disclose PHI other than as permitted or required by this Business Associate Addendum, any law or regulation.

c. Except as otherwise limited in this Business Associate Addendum, Delta Dental may use PHI for Delta Dental's proper management and administration or to carry out Delta Dental's legal responsibilities.

d. Except as otherwise limited in this Business Associate Addendum, Delta Dental may disclose PHI for Delta Dental's proper management and administration, provided that disclosures are Required By Law, or Delta Dental obtains reasonable assurances from the person to whom the PHI is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Delta Dental of any instances of which it is aware in which the confidentiality of the PHI has been breached.

2.3 Appropriate Safeguards. Delta Dental agrees to use appropriate safeguards to prevent its use or disclosure of PHI other than as provided for by this Business Associate Addendum.

2.4 Mitigation. Delta Dental agrees to mitigate, to the extent practicable, any harmful effect that is known to Delta Dental of a use or disclosure of PHI by Delta Dental in violation of the requirements of this Business Associate Addendum.

2.5 Reporting of Disclosures of PHI. As soon as practical after discovery, Delta Dental shall report to the Group Health Plan, or its designate, any use or disclosure of PHI by Delta Dental not provided for in this Business Associate Addendum of which Delta Dental becomes aware.

2.6 Agents and Contractors. Delta Dental shall ensure that any Delta Dental agent or subcontractor to whom Delta Dental discloses PHI agrees, in writing, to be bound by the same restrictions and conditions that apply to Delta Dental through this Business Associate Addendum.

2.7 Access to and Availability of PHI. Delta Dental shall, in accordance with HIPAA and as appropriate:

a. Provide access to the requested PHI within Delta Dental's or its agent's or subcontractor's possession. The Group Health Plan shall as soon as practicable forward to Delta Dental any requests the Group Health Plan receives from the individual. Delta Dental shall be responsible for responding to the Group Health Plan or individual who sent the request to Delta Dental. If the response is to be sent to the Group Health Plan, Delta Dental shall send the PHI to the Group Health Plan within fifteen (15) days of Delta Dental's receipt of the request.

b. Amend, notify appropriate recipients of any amendment, and incorporate any amendment to the requested PHI within Delta Dental's possession or its agent's or subcontractor's. The Group Health Plan shall as soon as practicable forward to Delta Dental any requests the Group Health Plan receives from the individual. Delta Dental shall be responsible for responding to the Group Health Plan or individual who sent the request to Delta Dental. If the response is to be sent to the Group Health Plan, Delta Dental shall send the response to the Group Health Plan within thirty (30) days of Delta Dental's receipt of the request.

c. Provide an accounting of disclosures of PHI as required by HIPAA. The Group Health Plan shall as soon as practicable forward to Delta Dental any requests the Group Health Plan receives from the individual. Delta Dental shall be responsible for responding to the Group Health Plan or individual who sent the request to Delta Dental. Delta Dental agrees to track, and request that its agents or subcontractors track, all such disclosures of PHI that would be required to respond to a request for accounting of disclosures of PHI as required by HIPAA. If the response is to be sent to the Group Health Plan, Delta Dental shall send the accounting to the Group Health Plan within thirty (30) days of Delta Dental's receipt of the request.

2.8 Availability of Delta Dental's Internal Practices, Books and Records. Delta Dental agrees to make its internal practices, books and records, including policies and procedures and PHI, relating to its use and disclosure of PHI available to the Group Health Plan, upon reasonable notice from the Group Health Plan, and the Secretary of Health and Human Services for purposes of determining Group Health Plan's and Delta Dental's compliance with this Business Associate Addendum and the HIPAA privacy standards.

2.9 Sponsor/Contractholder Compliance. If the Sponsor/Contractholder and/or Group Health Plan receives non-enrollment PHI from Delta Dental, then the Sponsor/Contractholder and/or Group Health Plan, as appropriate, shall be responsible for their compliance with HIPAA's administrative requirements resulting from the Sponsor/Contractholder's and/or Group Health Plan's activities including but not limited to, privacy officer designation, training, etc.

2.10 Sponsor/Contractholder Responsibilities. Sponsor/Contractholder and/or Group Health Plan agree to timely:

a. Forward any request it receives to the appropriate party as set forth in section 2.7 above,

b. Notify Delta Dental of any restriction, or any change thereto, to the use or disclosure of PHI that the Group Health Plan has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction(s) and/or change(s) may affect Delta Dental's use or disclosure of PHI; and

c. Notify Delta Dental of any changes in, or withdrawal of, any authorizations provided to the Group Health Plan by the individual and forwarded by the Group Health Plan to Delta Dental.

Unless otherwise specifically provided in this Business Associate Addendum, Delta Dental shall only be responsible to comply with the authorizations, restrictions or limitations conveyed by the Sponsor/Contractholder in accordance with this Section 2.10.

2.11 Term and Termination of the Contract and this Business Associate Addendum.

a. Term. The term of this Business Associate Addendum shall be effective on the effective date of the Contract and shall continue until the Contract is terminated.

b. Termination for Cause. The Sponsor/Contractholder may terminate this Business Associate Addendum and the Contract upon the Sponsor/Contractholder's knowledge that Delta Dental has materially breached this Business Associate Addendum if, within thirty (30) days after receipt of written notice of such material breach, Delta Dental fails to take action to cure the breach or end the violation. Sponsor/Contractholder may immediately terminate this Business Associate Addendum and the Contract if Delta Dental has breached a material term of this Business Associate Addendum and cure is not possible. If neither termination nor cure is feasible, Sponsor/Contractholder may report the violation to the Secretary of Health and Human Services.

c. In the event of any termination of this Business Associate Addendum, Delta Dental shall return or destroy all PHI that Delta Dental still maintains in any form and shall retain no copies. If return or destruction is not feasible because such PHI is necessary to fulfill Delta Dental's legal responsibilities or other management and administrative purposes, Delta Dental shall retain the PHI and shall continue to protect the confidentiality of PHI as required by this Business Associate Addendum. Delta Dental shall limit any use or disclosure of PHI to those purposes that make the return or destruction of PHI infeasible. Delta Dental agrees to require that any PHI in the possession of its agents or subcontractors be retained, returned or destroyed, as applicable.

d. The following sections shall survive termination of this Addendum: 2.7, 2.8, 2.11, 5.2, and 5.3.

2.12 Notice of Privacy Practices. Delta Dental's notice of privacy practices will be provided to the primary enrollees covered under the group dental plan administered by Delta Dental. However, Delta Dental and the Sponsor/Contractholder agree that Delta Dental will delegate the distribution of Delta Dental's notice to the Sponsor/Contractholder, and the Sponsor/Contractholder agrees to distribute, at no cost to Delta Dental, that privacy notice to the primary enrollees within the time frames required by HIPAA.

2.13 Security Rule Provisions. Delta Dental will comply with the following provisions by April 21, 2005, or such other applicable compliance date. For purposes of this section, "electronic protected health information" (ePHI) shall have the same meaning as defined in HIPAA and shall apply to those individuals who are eligible and/or enrolled in the Group Health Plan's dental benefit program administered by Delta Dental.

a. Delta Dental shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Group Health Plan.

b. Delta Dental shall ensure that any agent, including a subcontractor, to whom Delta Dental provides ePHI agrees to implement reasonable and appropriate safeguards to protect ePHI.

c. As soon as practical after discovery, Delta Dental shall report to the Group Health Plan any Security Incident of which Delta Dental becomes aware.

d. Delta Dental agrees to authorize termination of this Business Associate Addendum and the Contract as described in Section 2.11, above, by the Sponsor/Contractholder if the Sponsor/Contractholder has knowledge that Delta Dental has violated a material term of this Business Associate Addendum.

SECTION 3 – DISCLOSURE TO PLAN SPONSOR/CONTRACTHOLDER

3.1 Amendment of the Contract. Delta Dental and Sponsor/Contractholder agree to amend the Contract as set forth in this section to allow the Group Health Plan and/or Delta Dental to disclose non-enrollment PHI to the Sponsor/Contractholder.

3.2 Notice of Privacy Practices. Delta Dental's notice of privacy practices will advise that Delta Dental may disclose non-enrollment PHI to the Sponsor/Contractholder.

3.3 Disclosure of PHI to Plan Sponsor/Contractholder. The Sponsor/Contractholder represents and warrants that if the prior conditions in Sections 3.1 and 3.2 have been met, Delta Dental may disclose non-enrollment PHI to the classes of employees and other persons identified by Sponsor/Contractholder to carry out the plan administration functions. Delta Dental shall not disclose PHI to such persons for the purpose of employment-related actions or decisions or in connection with any other benefit plan of the Sponsor/Contractholder.

3.4 Identification of Employees and Other Persons. The Sponsor/Contractholder agrees that Delta Dental may rely upon the most recent list of classes of employees (or update thereof) provided by the Sponsor/Contractholder.

3.5 Disclosure of Enrollment and Summary Health Information. Sections 3.1 and 3.2 do not apply to disclosures of enrollment information and summary information as defined in HIPAA. Delta Dental may disclose to the Sponsor/Contractholder summary health information:

a. To obtain premium bids for providing dental benefits coverage under the Group Health Plan;

b. To modify, amend or terminate the Group Health Plan; or

c. As otherwise permitted by HIPAA.

3.6 Amendment of this Addendum as Group Health Plan Document. Sponsor/Contractholder and Delta Dental acknowledge that the Contract constitutes the group health plan document for the dental program administered by Delta Dental. This section 3.6 shall serve as the amendment to the group health plan document as required by HIPAA to permit Delta Dental to disclose non-enrollment PHI to the Sponsor/Contractholder. The provisions of this Section 3.6 control over any provision in the Contract that conflicts with this section.

a. Sponsor/Contractholder Certification. The following terms of this section incorporate the requirements of HIPAA to permit the Group Health Plan or Delta Dental to lawfully disclose non-enrollment PHI to the Sponsor/Contractholder or its agents. This section shall serve as the Sponsor/Contractholder's certification as required by HIPAA.

b. Permitted Uses and Disclosures.

i. Sponsor/Contractholder, its directors, officers, employees, contractors and agents shall use and/or disclose PHI received by Sponsor/Contractholder solely in accordance with the uses and disclosures described in Exhibit B which is attached to and made a part of this Business Associate Addendum.

ii. Sponsor/Contractholder shall not, and shall ensure that its directors, officers, employees contractors and agents do not, use or further disclose PHI in any manner except as permitted or required by this Business Associate Addendum or as required by law or regulation.

c. Agents and Subcontractors. Sponsor/Contractholder shall ensure that any agent or subcontractor that will have access to PHI from Sponsor/Contractholder agrees to be bound by the same restrictions, terms and conditions that apply to Sponsor/Contractholder pursuant to this Business Associate Addendum.

d. Employment-Related Actions and Decisions. The Sponsor/Contractholder shall not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit plan of the Sponsor/Contractholder.

e. Reporting of Disclosures of PHI. Sponsor/Contractholder shall, as soon as possible after becoming aware of an actual or suspected disclosure of PHI in violation of this Business Associate Addendum by Sponsor/Contractholder, its officers, directors, employees, subcontractors or agents or by a third party to which Sponsor/Contractholder disclosed PHI pursuant to this Business Associate Addendum, report any such disclosure to the Group Health Plan.

f. Access to and Availability of PHI. Sponsor/Contractholder shall timely and in compliance with HIPAA requirements:

i. Make available to the Group Health Plan or Delta Dental, as appropriate, the requested PHI to respond to an individual's request for access to PHI.

ii. Provide to the Group Health Plan or Delta Dental, as appropriate, the requested PHI to respond to a request for amendment and shall incorporate any amendment received from the Group Health Plan or Delta Dental.

iii. Make available to the Group Health Plan or Delta Dental, as appropriate, the requested PHI to respond to an individual's request for an accounting of disclosures of PHI.

The Sponsor/Contractholder agrees to track all disclosures of PHI that would be required to respond to a request for accounting of disclosures of PHI as required by HIPAA.

g. Availability of Sponsor's/Contractholder's Internal Practices, Books and Records. Sponsor/Contractholder agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the Group Health Plan or Delta Dental available to the Secretary of Health and Human Services for purposes of determining the Group Health Plan's and Sponsor/Contractholder's compliance with the HIPAA privacy standards.

h. Return or Destruction of PHI. Sponsor/Contractholder shall return or destroy all PHI received from the Group Health Plan or its agent that the Sponsor/Contractholder maintains in any form and shall retain no copies when such PHI is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, Sponsor/Contractholder shall continue to protect the confidentiality of PHI as required by this Business Associate Addendum and limit any use or disclosure of PHI to those purposes that make the return or destruction of PHI infeasible.

i. Adequate Separation. Sponsor/Contractholder shall ensure adequate separation as required by HIPAA by doing the following:

i. Sponsor/Contractholder shall identify the Sponsor/Contractholder's classes of employees or other persons to whom the Group Health Plan, its agent, or Delta Dental shall disclose PHI.

ii. Sponsor/Contractholder shall restrict access to PHI and use of PHI by such employees or other persons to the plan administration functions that Sponsor/Contractholder performs for the Group Health Plan.

iii. Sponsor/Contractholder shall implement an effective mechanism for resolving any issues of noncompliance by such employees or other persons, and such mechanism shall be consistent with the terms of this Business Associate Addendum.

j. Security Rule Provisions. Sponsor/Contractholder will comply with the following provisions by April 21, 2005, or such other applicable compliance date. For purposes of this section, "electronic protected health information" (ePHI) shall have the same meaning as defined in HIPAA and shall apply to those individuals who are eligible and/or enrolled in the Group Health Plan's dental benefit program administered by Delta Dental.

i. Sponsor/Contractholder shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Group Health Plan.

ii. Sponsor/Contractholder shall ensure that any agent, including a subcontractor, to whom the Sponsor/Contractholder provides ePHI agrees to implement reasonable and appropriate safeguards to protect ePHI.

iii. As soon as practical after discovery, Sponsor/Contractholder shall report to the Group Health Plan any Security Incident of which Sponsor/Contractholder becomes aware.

iv. Sponsor/Contractholder shall ensure adequate separation as required by HIPAA by complying with Section 3.6 (i) above for the ePHI created and received by the Sponsor/Contractholder.

SECTION 4 – DISCLOSURE TO BUSINESS ASSOCIATE

4.1 The Sponsor/Contractholder represents and warrants that prior to requesting Delta Dental to disclose PHI to the Group Health Plan's business associate(s), including but not limited to, a broker, consultant, TPA or auditor, the Group Health Plan, or the Sponsor/Contractholder on the Group Health Plan's behalf, shall have entered into a business associate contract or have other satisfactory arrangement with such business associate(s) that complies with the requirements of HIPAA. Sponsor/Contractholder and/or the Group Health Plan agree to provide Delta Dental with documentation relating to the business associate's permission to receive PHI from Delta Dental.

4.2 Disclosure to a business associate pursuant to this Section 4 shall not include a disclosure to the Sponsor/Contractholder nor to its identified employees.

SECTION 5 – GENERAL

5.1 Amendment to Business Associate Addendum. Sponsor/Contractholder and Delta Dental agree to amend this Business Associate Addendum as necessary to comply with federal or state laws or regulations relating to the administrative simplification provisions of HIPAA.

5.2 Indemnification by Delta Dental. Delta Dental agrees to indemnify, defend and hold harmless the Group Health Plan, or the Sponsor/Contractholder on the Group Health Plan's behalf, and their employees, directors, officers, subcontractors, agents or other members of its workforce, each of the foregoing hereinafter referred to as "Indemnified Party," against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with Delta Dental's breach of sections 2 or 3 of this Business Associate Addendum. Accordingly, on demand, Delta Dental shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from Delta Dental's breach hereunder. Delta Dental's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Business Associate Addendum for any reason.

5.3 Indemnification by Group Health Plan or Sponsor/Contractholder. The Group Health Plan, or the Sponsor/Contractholder on the Group Health Plan's behalf, agrees to indemnify, defend and hold harmless Delta Dental and its employees, directors, officers, subcontractors, agents or other members of its workforce, each of the foregoing hereinafter referred to as "Indemnified Party," against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with the Group Health Plan's or Sponsor/Contractholder's breach of Sections 2, 3 or 4 of this Business Associate Addendum. Accordingly, on demand, the Group Health Plan or Sponsor/Contractholder shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Group Health Plan's or Sponsor/Contractholder's breach hereunder. The obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Business Associate Addendum for any reason.

5.4 Interpretation. This Business Associate Addendum shall be interpreted to allow the parties to comply with HIPAA, provided, however, that nothing herein shall be construed to grant rights beyond those provided under HIPAA or applicable law.

5.5 No Third Party Beneficiary. Nothing express or implied in this Business Associate Addendum is intended to confer, nor shall anything in this Business Associate Addendum confer, upon any person other than the parties to this Business Associate Addendum and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

IN WITNESS WHEREOF, Sponsor/Contractholder and Delta Dental have duly executed this Business Associate Addendum as of the date listed below.

Sponsor/Contractholder represents and warrants that it is signing this Addendum in its capacity as the sponsor of the Group Health Plan and not in a capacity of a business associate to the Group Health Plan.

Sponsor/Contractholder: _____
(print entity's name)

Group Contract Number: _____

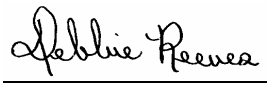
Signature: _____

Print Name: _____

Print Title: _____

Date: _____

Delta Dental Insurance Company

Signature: 

Print Name: Debbie Reeves

Print Title: Vice President, Marketing Administration

Date: _____

EXHIBIT A TO HIPAA BUSINESS ASSOCIATE ADDENDUM: GROUP HEALTH PLAN

Delta Dental's Permitted Uses and Disclosures:

Except as otherwise limited in this Business Associate Addendum, Delta Dental shall use and disclose PHI:

A. To perform the functions, activities, or services for, or on behalf of, the Group Health Plan as specified in the Contract, provided that such use or disclosure would not violate HIPAA if done by the Group Health Plan.

B. For the Group Health Plan's treatment, payment and health care operations as defined and permitted under HIPAA with respect to Delta Dental's administration of the dental benefits program for the Group Health Plan as described in the Contract.

C. For Delta Dental's treatment, payment and health care operations as defined and permitted under HIPAA with respect to Delta Dental's administration of the dental benefits program for the Group Health Plan as described in the Contract.

D. To Delta Dental's agents or subcontractors as necessary for Delta Dental to perform the services described in the Contract.

E. To the Group Health Plan's or Sponsor/Contractholder's business associate, agent or subcontractor as requested by the Sponsor/Contractholder.

F. To provide Data Aggregation services to the Group Health Plan if mutually agreed upon between Group Health Plan and Delta Dental.

G. To provide to or obtain de-identification services for the Group Health Plan if mutually agreed upon between Group Health Plan and Delta Dental.

H. As otherwise required or permitted by HIPAA or federal or state law.

I. To report violations of law to appropriate federal or state authorities, consistent with 45 CFR §164.502 (j) (1).

J. As otherwise requested by the Sponsor/Contractholder or the Group Health Plan that is not in violation of HIPAA.

EXHIBIT B TO HIPAA BUSINESS ASSOCIATE ADDENDUM: GROUP HEALTH PLAN

Sponsor/Contractholder's Uses and Disclosures

Sponsor/Contractholder shall use and disclose PHI only in compliance with HIPAA and for the purpose of providing plan administration functions to the Group Health Plan. Plan administrative functions are defined as administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

Delta Dental Insurance Company
Alpharetta, GA 30022
(770) 645-8700

Small Employer Group Dental Insurance Application

Delta Dental's Administrator's Use ONLY
PPO Group #: _____
DeltaCare® USA#: _____

Name of Applicant: _____

Type of Industry: _____ **SIC Code:** _____ **Fed ID/TIN#:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Name of Contact Person: _____ **Telephone No.:** _____

Fax No.: _____ **Email Address:** _____

Billing Address if different: _____ *Contact:* _____

Fax No.: _____ *Email Address:* _____

Program ID #: _____ **Contract Effective Date:** _____ **Length of Contract:** 1 year

Program Type: (Check one): ☐ ☐ ☐ ☐ ☐

	Program A	Program B	Program C	Program E		Program Vol
				High	Low	
Diagnostic & Preventive	100%	100%	100%	100%	100%	100%
Basic	80%	80%	100%	80%	50%	80%
Major	50%	50%	50%	50%	50%	50%
Endo/Perio	Basic	Major	Major	Basic	Basic	See below*
Oral Surgery	Basic	Major	Major	Basic	Basic	See below*
Calendar Year Deductible	$50/$150	$50/$150	$25/$75	$50/$150	$75/$225	$50/$150
Deductible waived on D&P?	Yes	Yes	No	Yes	Yes	Yes
Waiting Period **	None	None	None	None	None	12 month
Calendar Year Maximum (Check One)		☐ $1,000 ☐ $1,500		☐ $1,000 High/$750 Low ☐ $1,500 High/$1,000 Low		☐ $1,000 ☐ $1,500
50% Child/Student Only Ortho Option (Check one) ☐ Yes ☐ No						
Lifetime Ortho Maximum (Check One)		☐ $1,000 ☐ $1,500***		☐ $1,000 High / $750 Low ☐ $1,500 High/$1,000 Low ***		☐ $1,000 $350 per year applied to yearly maximum

* Program Vol: ☐ 1 Endo/Perio/Oral Surgery at Major ☐ 2 Endo/Perio at Basic, Oral Surgery at Major

**Applies to Major and Ortho, if covered and is waived for all employees with continuous coverage under Applicant's prior dental plan.

Programs A - E: Teeth missing prior to the effective date are covered.

Program Vol 1 & 2: Teeth missing prior to the effect date are **not** covered unless extracted under the Applicant's prior dental plan, if any, and Section 125 is required.

Fee Basis (Check one): ☐ PPO in/PPO out ☐ PPO in/MPA out

***Available for employer contributions of 75% or more

Employer Contribution (Check one)	☐ 75% – 100%	☐ 50% – 74.9%	☐ 0% – 49.9%
	Program A-C and Program E	Program A-C and Program E	Program Vol 1 & 2

PPO Rates

Payment Mode: ☒ Monthly

☐ Two Tier: EE: $ _____ EE & family: $ _____

☐ Three Tier: EE: $ _____ Two Party: $ _____ Three Party: $ _____

☐ Four Tier: EE: $ _____ EE & spouse: $ _____ EE & child(ren): $ _____ EE & Family: $ _____

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Delta Dental. 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 prevent recovery if, had the true facts been known to Delta Dental we would not in good faith have issued the contract at the same premium rate. It is agreed that premium and a current eligibility list will be submitted to Delta Dental's designated Administrator by the twenty-fifth day of the month prior to the coverage month.

Executed this ____ day of _____, 20____ for the Applicant at: _____
City and State

By: _____ Signature: _____
(please print – name and title)

(Continued)

Small Employer Group Dental Insurance Application *(Continued)* Applicant's Name: _____

Census: _____ # of Employees **Minimum for Enrollment :** Delta Dental PPO: 5 Primary Enrollee
DeltaCare USA: 3 Primary Enrollees

_____ # of Employees Participating in PPO Program

_____ # of Employees Participating in DeltaCare USA Program

Takeover: ☐ Yes ☐ No Name of previous carrier: _____

Eligibility: # of Months: _____ or # of Days: _____ Hours / week: _____

Employee Effective Date: 1st day of the month following completion of eligibility ☐ Date of hire ☐
1st day of month following date of hire ☐ Day following completion of eligibility ☐

Who is eligible: All Employees ☒ Children to age: 19 Students to age: 26

Dual Choice with a DeltaCare USA Program? ☐ No ☐ Yes.

DeltaCare USA Program (check one)

☐ Plan 13A ☐ Plan 15B
☐ Plan 14B ☐ Plan 15C

Employer Contribution (Check one):

☐ 0% – 49.9%
☐ 50% – 74.9%
☐ 75% – 100%

DeltaCare USA Rates

☐ Two Tier: EE: $ _____ EE & family: $ _____
☐ Three Tier: EE: $ _____ Two Party: $ _____ Three Party: $ _____
☐ Four Tier: EE: $ _____ EE & spouse: $ _____ EE & child(ren): $ _____ EE & Family: $ _____

Agent/Broker Information Are you appointed with Delta Dental Insurance Company? ☐ Yes ☐ No

Name: _____ Telephone #: _____ Fax #: _____
Company Name: _____ Company is Inc.? ☐ Yes ☐ No
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
TIN or SS#: _____ State & State License #: _____ Email address: _____
Agent Signature: _____ Date: _____

General Agent Information

Name: _____ Telephone #: _____ Fax #: _____
Company Name: _____ Company is Inc.? ☐ Yes ☐ No
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
TIN or SS#: _____ State & State License #: _____ Email address: _____
GA's Signature: _____ Date: _____

Accepted for Delta Dental Insurance Company
This _____ day of _____, _____
Authorization _____ initials

_____
Anthony S. Barth, President
Delta Dental Insurance Company

DELTA DENTAL
Delta Dental Insurance Company

DENTAL HEALTH PLAN

Delta Dental (800) 521-2651
DeltaCare (800) 422-4234

Make Your Coverage Selection

o Delta Dental o DeltaCare o POS Option (See Reverse)

(DeltaCare, a dental HMO, is provided by Alpha Dental Programs and administered by PMI Dental Health Plan)

ENROLLMENT/CHANGE FORM

TEXAS ONLY

FOR EMPLOYER USE ONLY

Effective Date / /	Group No. (DDIC)
Full Time Hire Date / /	Group No. (DeltaCare)
Sublocation	

Check One (**Enrollees can change plans only during open enrollment)

- o New Hire
- o Open Enrollment
- o Change Dental Plans**
- o COBRA
- o Add/Delete Dependent
- o Terminate Employee Coverage
- o Spouse Employment Change
- o Marital Change
- o Other _____

Indicate qualifying date: (Month) (Day) (Year)

COBRA Enrollment Only

- o Termination
- o Reduction in Hours
- o Divorce
- o Widowed/Surviving Dependent
- o Dependent Child No Longer Eligible

Indicate qualifying date: (Month) (Day) (Year)

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: (Last, First, Middle)

Mailing Address: (Street Address)

(City) (State) (Zip) (Pay period - if applicable)

Social Security # ___ — ___ — ___ Date of Birth: (Month) (Day) (Year)

Name of Employer/Group Location

Marital Status: Single o Married o Gender: Male o Female o Phone # ( ) —

Do you have dependent children? Yes o No o Are you or your dependents covered under another dental plan? Yes o No o

DeltaCare Only (DHMO)

Network Facility Name: Network Facility #:

Dependent Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF				**DeltaCare Only**	
Dependent Name	Add/Delete	Male/Female (Check One)	Date of Birth (Month) (Day) (Year)	Network Facility Name	Network Facility #
Spouse:	o o	o o			
Dependent:	o o	o o			
Dependent:	o o	o o			
Dependent:	o o	o o			
Dependent:	o o	o o			
Dependent:	o o	o o			
Dependent:	o o	o o			

o **Delta Dental**-CANCEL o **DeltaCare**-CANCEL o **POS Option**-CANCEL

DeltaCare Only

What is your primary language? o English o Spanish o Other _____

Do you have a disability affecting your ability to communicate or read which could be accommodated by providing you an Evidence of Coverage in a specific format?

o Yes o No If so, what format? _____

- o I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.
- o I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____