

Please confirm that the following is submitted with all new cases.

- Completed application for group dental insurance
- Completed employee enrollment forms or census spreadsheet (*census is preferred for ease of processing*)
- Online agent-generated proposal from www.directbenefits.com
- If paying by ACH, please complete the included form and provide a copy of a voided check
- If paying by check, include a copy of the Binder Check

If applicable, please confirm that all of the following documentation is provided prior to coverage on take-over cases:

- Copy of Prior Carrier's summary of benefits
- Copy of Prior Carrier's most recent billing statement

Policy Documents Delivery Acknowledgement

Policy documents will be delivered how requested on the master application. ID cards will be mailed to the employer for distribution.

After all the information listed above is completed and signed, submit all forms using one of the following delivery methods:

Email: agentsupport@directbenefits.com

Fax: 651-649-3502 ATTN: Group Sales

Mail: Direct Benefits, Inc.
55 East 5th Street, Suite 500
Saint Paul, MN 55101

***Please send hard copy of binder check to the address above**

Submission Date:

New groups should be received no later than the 8th of the month of the desired effective date in order to submit to the carrier (*i.e. Feb 1st effective date, please submit to Direct Benefits by Feb 8th*).



DirectBenefits
AN ALERA GROUP COMPANY



Delta Dental of Nebraska
 Atrium Executive Square
 11235 Davenport Street, Suite 113
 Omaha, NE 68154



55 East Fifth Street, Suite 500
 Saint Paul, MN 55101
 www.directbenefits.com
 Phone: 800-620-5010

PathfinderSM

DENTAL

Thank you for choosing Delta Dental. Please take a moment to complete this form. This form along with your enrollment data and sold proposal will be used to set up your client with Delta Dental.

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

Instructions:

1. Complete Client Information Form
2. Have each employee complete an Enrollment Form, or work with your Delta Dental Connect Representative to complete an Enrollment Spreadsheet
3. Send this completed application, completed Enrollment Forms, as well as the completed ACH form, voided check, and the initial remittance (if applicable) to the following address:
Direct Benefits, Inc., 55 East Fifth Street, Suite 500, Saint Paul, MN 55101

CLIENT INFORMATION FORM

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

Client ID Number (Assigned by Delta Dental): _____

Client Name: _____

Plan: Nebraska

Client Tax Identification/EIN #: _____

Eligible Employees: _____

Effective Date: _____ Contract Length: 1 year 2 years

Physical Location: _____

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

CLIENT CONTACT INFORMATION

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

Title: _____

Contact Type: General Renewal Billing Mailing Materials Over-age Dependent (BMT Only)

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

Fax: (_____) _____ Email Address: _____

Same as Client Physical Location

Address: _____

City: _____ State: _____ ZIP Code: _____

OTHER CLIENT CONTACT INFORMATION (if the billing contact is different from above)

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

Title: _____

Contact Type: Billing

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

Fax: (_____) _____ Email Address: _____

Same as Client Physical Location

Address: _____

City: _____ State: _____ ZIP Code: _____

CLIENT - BENEFIT MANAGER TOOLKIT REGISTRATION

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, and print dentist directories. In addition, **your monthly invoice and other billing details are provided to you exclusively through BMT.**

Select a Client Administrator within your company and complete the information below. This administrator will be able to create and maintain your accounts, enabling immediate access for your BMT users. Delta Dental will send your administrator an email with registration information and additional instructions.

Administrator Name: _____ Title: _____

Email: _____ Phone Number: _____

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

AGENT/AGENCY - BENEFIT MANAGER TOOLKIT AUTHORIZATION

I **authorize** that the assigned Agent/Agency (below) 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
- VIEW ELIGIBILITY ONLY
- BILLING DETAILS

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

Authorized Signature: _____ Date: _____

ADDITIONAL INFORMATION

Prior Carrier? Yes No (if yes, please provide a current copy of invoice and benefit summary from prior carrier)

Name of Prior Carrier: _____ Prior Plan Start Date: _____

Pathfinder Value: If a group has at least 12 continuous months of coverage with a \$100 Lifetime Deductible and is electing a Pathfinder plan with \$100 Lifetime Deductible, then initial members enrolled will receive \$100 Lifetime Deductible credit. Yes No

FOR AGENTS ONLY

In order to properly assign the correct agent and agency, please ensure all information is complete and accurate. If the information below differs from our records, this may cause a delay in processing or in order to complete the request, it may cause the initial Welcome Packet to be issued without the agent of record information.

Agent Name: _____

Agency Name: _____

Checks to: Agency Agent

New agent/agency? Yes No If yes, please complete the Agent Appointment Application online <http://www.deltadentalne.org/appointment/#/application/get-started>

TIN: _____

NPN#: _____ Insurance Producer License ID #: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: (_____) _____ Fax Number: (_____) _____

Cell Phone:(_____) _____ Email Address: _____

Another Agent? Yes

*If commission is split please provide percentages: TIN/SSN _____ Agent _____ %
TIN/SSN _____ Agent _____ %

Start Date: _____

Contact Agent Name (if different than above): _____

Telephone: (_____) _____ Fax Number: (_____) _____

Cell Phone:(_____) _____ Email Address: _____

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: _____

BILLING CONFIGURATION

Bill Type (How would you like to receive your bill?): Mail Email Notification Only (Benefit Manager Toolkit)

Payment Method: Check ACH (DDNE initiated ACH)

SUBCLIENT INFORMATION

- The account structure is used for reporting and accounting purposes.
- Delta Dental will assign a client number.
- Subclient names/numbers will be assigned unless directed otherwise.
- If you prefer to modify, please note that subclient numbers consist of four digit numeric or alpha characters.

Please review the Dental Account Structure below carefully.

CLIENT NUMBER	SUBCLIENT NUMBER	SUBCLIENT NAME

BILL CONSOLIDATION

All subclients will be **billed collectively** unless directed otherwise.

For BMT access when one Subclient is set up, bills can be found under non-consolidated and consolidated for multiple subclients.

Please indicate below any bill consolidation requirements:

1. _____
2. _____
3. _____

ELIGIBILITY AGE LIMITS FOR DEPENDENT CHILD(REN)

Age dependent child(ren) coverage ends: 26

When does dependent child(ren) coverage end? End of Month

COB PROCESSING INFORMATION

Payment Option Type: Standard

Support Internal COB (Spouses with the same employer can cover each other): Yes No

Support External COB (Spouses with different employers can cover each other): Yes No

SUBSCRIBER DEFINITION (by subclient, if applicable)

Example: All full-time employees of the Contractor working at least 30 hours per week.

NEW EMPLOYEE/MEMBER PROBATION PERIOD (WAITING PERIOD)

Example: *On the first day of the month following 90 days of employment*

- 1st of the Month Following _____ Days
- Hire Date
- Employer Determined: _____

TERMINATION LANGUAGE (when should coverage end)

- Term at End of Month

DOMESTIC PARTNER COVERAGE

Domestic Partner Covered? Yes No

EMPLOYEE CONTRIBUTION

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

- _____% **Employer** Contribution for Employee
- _____% **Employer** Contribution for Dependents
- ____ Other Contribution

ENROLLMENT

Open Enrollment: Annual/All (Subscribers & Dependents) (Groups with 5 or more enrolled) None (under 5)

If yes, Open Enrollment Dates: _____

Initial Enrollment Format:

- Enrollment Forms
- Delta Dental’s one-time load layout (Excel File)

Anticipated Date of Receipt: _____ **Who Will be Sending:** _____

Ongoing Enrollment (used to make adds, changes, and terminations going forward):

- Enrollment Forms
- Online Dental Portal (Benefit Manager Toolkit)

Benefit Dates:

Coverage period for annual deductibles and maximums:

- Calendar Year(January through December)

AGREEMENT

The undersigned client hereby adopts and subscribes to the terms and provisions in this form and certifies to the best of his/her knowledge and belief, all the responses are true, correct and complete. I verify that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested.

If Delta Dental accepts this application, Delta Dental will send a contract to Company upon acceptance. The contract will indicate the effective date of coverage. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two.

Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether the Company executes the contract.

In addition to the commissions and/or fees identified specifically for your plan, the Agency/Agent may qualify for additional compensation payments from Delta Dental related to your purchase of a Delta Dental benefit plan. This additional compensation is not charged to your plan. The Agent/Agency of Record has full authority to act on the client's behalf in all matters concerning the client's dental benefits administration, including but not limited to contractual matters and changes to the client's contract.

Misrepresentation or fraud will cause your contract to be null and void from the start and may be in violation of state law.

Payment of the first month's rate for the proposed Delta Dental program(s) and a copy of the proposal must accompany this form.

Signature of Client's Authorized Official: _____ Date: _____

Printed Name: _____

Title: _____

Signature of Selling Agent: _____ Date: _____

Printed Name: _____

Title: _____

Amount Received: \$ _____ Check Number: _____

[Binder Checks and Future payments can be mailed to:

Please include Client ID and Client Name

Delta Dental of Nebraska
NW 5767
PO Box 1450
Minneapolis, MN 55485-5767]



**DIRECT DEBIT AUTHORIZATION
VIA ACH (Automatic Withdrawals)**

Delta Dental of Nebraska

Client Name: _____

Client Number: _____

Client Sub-location Number(s): _____

Effective Date: _____

Financial Institution Information:

Bank Name: _____

Bank Address: _____

ABA (Routing) Number: _____

Account Number: _____

Type of Account: _____

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above in accordance with my underlying contract with Delta Dental and Delta Dental's ACH processing policies. I understand that I am responsible for any fees incurred due to the ACH being rejected or returned for any reason by my bank and collection action may be taken.

This authorization will remain in full force and effect until Delta Dental has received written notification from me of its termination in such time as to afford Delta Dental and the Financial Institution a reasonable opportunity to act on it, or until all of my payment obligations under the contract have been satisfied.

Should you have any questions regarding your Direct Debit (ACH) Instructions, please contact the Accounting Department at 1.800.838.8863 or at billing@mydeltadental.com.

Office hours are Monday through Friday, 8 a.m. to 5 p.m. EST.

Authorized Signature: _____ Date: _____

Printed Name: _____ Phone Number

BENEFIT MANAGER TOOLKIT®

A cutting-edge tool to simplify your life.

You can update your group's eligibility online, real time, using our Web-based tool called Benefit Manager Toolkit (BMT). You can enroll a new member, update existing members, or simply view eligibility. You can view your benefits, print dentist directories, and access flexible and convenient reports (if your group qualifies for reports).

In addition, you have control over your company's accounts. Select a Client Administrator within your company using the form below. This administrator will be able to set up and maintain your BMT accounts, enabling immediate access for your users.

Streamline your benefits management process using Benefit Manager Toolkit!

- ➔ Get **real-time** benefit and eligibility information, without a phone call
- ➔ Take control of your group's eligibility – enter, edit, and terminate member eligibility immediately...no wait time
- ➔ Download dentist directories in a printable format
- ➔ View your billing details
- ➔ Create BMT accounts for your company, maintain security levels for your users, and disable accounts when roles change or the person leaves your company

NOTE: The BMT Administrator must be an employee of the client/group

Please complete the following information to name your company's Benefit Manager Toolkit administrator:

Client Information		
CHECK <input checked="" type="checkbox"/> NEBRASKA		
CLIENT NAME	CLIENT NUMBER	SUBCLIENT NUMBERS
Administrator Information		
NAME	TITLE	
EMAIL	PHONE NUMBER	

Delta Dental will send your administrator an email with registration information and further instructions.

Please forward your completed BMT form to:

Mail: Delta Dental
Attn: Group Administration
P.O. Box 30416
Lansing, MI 48909-7916

Email: groupadministration@MyDeltaDental.com

Fax: (517) 347-5135

www.deltadentalne.org

Eligibility Enrollment/Update

NO FORM IS REQUIRED IF WAIVING DENTAL BENEFITS

Delta Dental of Nebraska

Client Name: Client#/Subclient# -

EXAMPLE:

Plan Enrollment/Update Information *(please indicate type of update and fill in appropriate information):*

Type of Update: New Enrollment Reinstatement Change/Correction to Information Termination of Benefits Delta Dental Transfer

Group/Subgroup From: Client/Subclient# - To: Client/Subclient# - Effective Date of Change - - Change is for: Subscriber Spouse Dependent

Subscriber Information *(please complete for all enrollments/updates:)*

Subscriber Name (Last) (First) (M.I.) Sex Male Female Status* Active Retiree COBRA Surviving

Subscriber Social Security Number - - Birth Date - - Coverage Effective Date - - Hire Date - -

Street Address Check here if this is a new address

City State ZIP Code -

Enrollment/Corrections to Information *(please fill in for spouse/dependents for first-time enrollment or corrections):*

SPOUSE Name (Last) (First) (M.I.) Sex Male Female

Social Security Number Birth Date - - Status* Legal Surviving

SSN IS NOT REQUIRED

DEPENDENT #1 Name (Last) (First) (M.I.) Sex Male Female

Social Security Number Birth Date - - Status* IRS Dep. Surviving Disabled Sponsored

ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH

DEPENDENT #2 Name (Last) (First) (M.I.) Sex Male Female

Social Security Number Birth Date - - Status* IRS Dep. Surviving Disabled Sponsored

ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH

DEPENDENT #3 Name (Last) (First) (M.I.) Sex Male Female

Social Security Number Birth Date - - Status* IRS Dep. Surviving Disabled Sponsored

ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH

DEPENDENT #4 Name (Last) (First) (M.I.) Sex Male Female

Social Security Number Birth Date - - Status* IRS Dep. Surviving Disabled Sponsored

ONLY REQUIRED FOR DEPENDENTS WITH THE SAME DATE OF BIRTH

*See reverse side for instructions and explanation of codes.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize payroll deduction from my earning for any contribution I am required to make.

Subscriber's Signature _____ Date _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information – This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

- Active:** You are a current/active subscriber.
- Retiree:** You are retired and your group continues to provide you with dental benefits.
- COBRA:** You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose group medical benefits coverage. **Please check with your human resources or personnel department.**
- Surviving:** The surviving spouse or child of a deceased subscriber.

Plan Enrollment/Update Information – This section should only be completed if you are: (1) Enrolling yourself or a family member for the first time, or (2) if your benefits were terminated and are not being reinstated or, (3) if you are making changes to your current enrollment information.

- Enrollment:** Check for first time enrollment for yourself or your dependents.
- Reinstatement:** Check for reinstatement coverage for yourself or your dependents.
- Change/Corrections:** Check if any changes are being submitted on the form.
- Termination of Benefits:** Check only if you are terminating Delta Dental coverage for yourself or a family member.
- Group Transfers:** When transferring from one group to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled “from” and the correct information should be listed on the line titled “to”.

Enrollment/Corrections To Information – This section should be completed when: (1) enrolling dependents or, (2) if you have checked Changes/Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

- Legal:** Your current spouse
- Surviving:** The surviving spouse or child of a deceased subscriber.
- IRS Dependent:** An individual who is your dependent child according to the U.S. Internal Revenue Code. This could include your unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.
- Disabled:** Your permanently disabled child.
- Sponsored:** A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, **but only if specified in your group’s contract with Delta Dental.**



Direct Benefits, Inc
55 Fifth Street East, Suite 500
St Paul, MN 55101