DELTA DENTAL
Delta Dental of Rhode Island

GROUP APPLICATION
For
Chamber of Commerce Benefit Plan

The purpose of this form is to confirm the level of benefits, rates, and billing information for the group specified below.

COMPANY INFORMATION

Group Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____
_____ Administrative Contact: _____
City: _____ State: _____ Zip: _____
Billing Address (If Different): _____
President/Owner: _____
Tax ID#: _____ Type of Business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

PLAN DESCRIPTION

Effective Date of Coverage: _____ /01/ _____
Standard Chamber of Commerce Benefit Plan

Level I:	Preventive, Diagnostic and Minor Restorative	100%
Sealants:		50%

Six month waiting period for all Level II services including crowns and periodontics

Level II:	Major Restorative	50% *
	Crowns:	50% *
	Periodontics:	50% *

* $50 per person/$100 per family annual deductible Calendar Year Maximum $1,200 per person
Reduced Benefits for Services Provided by Non-participating dentists

FINANCIAL ARRANGEMENT

Rates are valid through December 31 of each year

Monthly Rates: **Individual** _____ **Two Person** _____ **Family** _____

First Month's Estimated Premium (Due With Application):

Number of Single Employees: _____ x $ _____ = $ _____
Number of Two Person Employees: _____ x $ _____ = $ _____
Number of Family Employees: _____ x $ _____ = $ _____
Total Employees: _____
Amount Payable to Delta Dental of Rhode Island: $ _____

I am a member of the _____ Chamber of Commerce and hereby apply for the Delta Dental of Rhode Island plan outlined above.

1. I certify that the company named above is a bonafide business and is not in operation for the sole purpose of obtaining insurance.
2. I have read the enclosed information and understand that 100% of my eligible employees must participate in the Plan.
3. I certify that all employees enrolled in this Delta Dental plan are actively working a minimum of 30 hours per week for financial compensation and that said employees are covered by Workers Compensation as required by law. Delta Dental retains the right to request documentation at any time.
4. Employees hired prior to effective date are eligible for enrollment immediately. Employees hired after the effective date must enroll within 60 days of employment.
5. I understand that the employer is responsible to pay all premiums by the first of the month for which the dental plan is in effect.
6. I understand that membership in a Rhode Island Chamber of Commerce must be continuously maintained and failure to do so will result in termination of this coverage.
7. Delta Dental of Rhode Island retains the right to terminate this agreement at any time if the statements made herein are not true and complete, or if the employer fails to provide the above information if requested.

Authorized Signature: _____ **Date:** _____

Account Executive: _____ **Broker (if applicable):** _____
Underwriting Approval: _____ **Group Number Assigned:** _____