

Master Dental Application

PART A - COMPANY INFORMATION

Legal Company Name: _____	Phone: _____
Address: _____	County: _____
City: _____	State: _____ Zip Code: _____
Plan Effective Date: _____	
<u>Group Information</u>	
Contract Information:	Minnesota Service Cooperative
First Name: _____	<input type="checkbox"/> Lakes Country Service Cooperative
Last Name: _____	
Business Title: _____	<input type="checkbox"/> North East Service Cooperative
Business Phone: _____	
Business Fax: _____	<input type="checkbox"/> Northwest Service Cooperative
Email Address: _____	
Billing Contact Information: (If different than Contact Information)	<input type="checkbox"/> Resource Training & Solutions
First Name: _____	
Last Name: _____	<input type="checkbox"/> South Central Service Cooperative
Business Title: _____	
Business Phone: _____	<input type="checkbox"/> Southeast Service Cooperative
Business Fax: _____	
Email Address: _____	<input type="checkbox"/> SW/WC Service Cooperative

PART B - PLAN DESIGN

<input type="checkbox"/> Plan A
<input type="checkbox"/> Plan B
<input type="checkbox"/> Plan C

PART C - FUNDING TYPE

<input checked="" type="checkbox"/> RISK: The first month's premium check must accompany this completed Master Dental Contract Application. Future premium payments are due on the first of each premium month.

PART D - PAYMENT METHOD

<input type="checkbox"/> Check
<input type="checkbox"/> ACH

PART E - AGENT OF RECORD (if applicable)

Agency Name: _____ Address: _____ City: _____	Broker Name: _____ Phone: _____ Fax: _____ State: _____ Zip Code: _____ _____ Tax ID Number (TIN) Note: Commissions will be paid to this TIN. _____ Insurance Producer License ID Number
_____ Broker Signature	_____ Insurance Producer License ID Number

PART F - INSTRUCTIONS

1. Complete Master Dental Contract Application.
2. Have each employee complete and sign a Membership Enrollment Form
3. Send this completed application, completed Membership Enrollment Forms, and the initial remittance to the following address:
National Insurance Services, Karen Patraw, 14852 Scenic Heights Road, Suite 210, Eden Prairie, MN 55344

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are, in fact employed by my company and agree to provide substantiating evidence when requested. 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 five.

Delta Dental will send a contract upon acceptance of the application and final approval of the Dental Benefit Plan Summary. The contract will indicate the effective date of coverage. The contract is effective only after Delta Dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental.

SIGNATURE BOX

Signature of Authorized Company Official	Title	Date
Group Administrator/Future Correspondence Contact (please print)	Title	
() Phone Number	() Fax Number	E-mail Address