DELTA DENTAL OF MINNESOTA

Master Dental Application
Minnesota Service Cooperatives

PART A – COMPANY INFORMATION

Legal Company Name: _____

Address: _____ Phone: _____

_____ County: _____

City : _____ State: _____ Zip Code: _____

Plan Effective Date: _____

Contract Location:

First Name: _____

Last Name: _____

Business Title: _____

Business Phone: _____

Business Fax: _____

Email Address

Billing Contact Information: (If different than Contact Information)

First Name: _____

Last Name: _____

Business Title: _____

Business Phone: _____

Business Fax: _____

Email Address _____

Minnesota Service Cooperative:

- ☐ Lakes Country Service Cooperative
- ☐ North East Service Cooperative
- ☐ Northwest Service Cooperative
- ☐ Resource Training & Solutions
- ☐ South Central Service Cooperative
- ☐ Southeast Service Cooperative
- ☐ SW/WC Service Cooperative

PART B – PLAN DESIGN

☐ Voluntary

☐ Contributory Amount of Contribution _____

☐ Orthodontics $ 1,000 LTM to age 19 (Plan D Only, Minimum 10 enrolled employees)

- ☐ Plan A
- ☐ Plan B
- ☐ Plan C
- ☐ Plan D

PART C – FUNDING TYPE

☐ 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

- ☐ Check
- ☐ ACH

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PART E – AGENT OF RECORD (if applicable)

Agency Name: _____ Broker Name: _____
Address: _____ Phone: _____
_____ County: _____
City _____ State: _____ Zip Code: _____

_____
TAX ID Number (TIN)
Note: Commissions will be paid to this TIN

_____ _____
Broker Signature Insurance Producer License ID Number

PART F - INSTRUCITONS

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, 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 Benefits 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 Email Address