DELTA DENTAL®

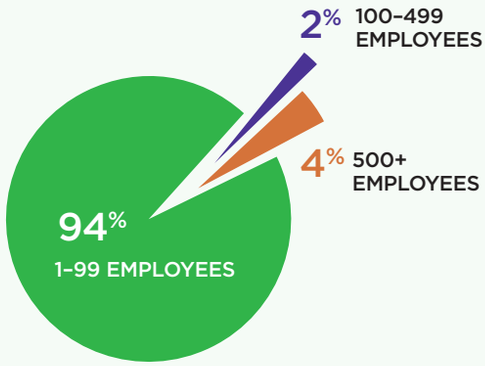
DENTAL & VISION BENEFITS

FOR ARKANSAS SMALL BUSINESSES (2 – 50 EMPLOYEES)

Plans and rates valid through December 31, 2021

In Arkansas, small business is a big deal.

ARKANSAS BUSINESSES BY NUMBER OF EMPLOYEES



Source: 2015 Statistics of U.S. Businesses, United States Census Bureau

OFFERING A RANGE OF BENEFIT CHOICES — EVEN IF THE EMPLOYEE BEARS THE COST — IS AN INVESTMENT SMALL BUSINESSES CAN'T AFFORD TO IGNORE.

Small businesses are the lifeblood of Arkansas' economic development and growth.

Small businesses make up 94% of the 50,000+ businesses in the Natural State. Businesses with less than 100 employees provide jobs for 35% of our state's private workforce.

Starting and running a business is an exciting proposition, but it's also an incredibly challenging undertaking.

The top area that continues to be a challenge for small business owners is that of hiring and keeping productive employees. Employee benefits play an important role in the lives of employees as well as their families. For that reason, the benefits you offer can be a factor for a potential employee's decision to work at your business. Yet the rising cost of insurance — both health care and other benefits — is another challenge which continues to face small businesses.

Help protect your greatest investment

Employees are a small business owner's greatest investment, and it's difficult to balance protecting employee health and managing a budget.

That's why we've specially designed a portfolio of dental and vision plans to help small businesses with as few as two employees meet their benefit goals. We deliver valuable benefits at affordable rates, we eliminate complicated benefits administration and we cover more than the bare minimum with rich plan designs — that's the **Delta Dental Difference.®**

Our Small Business Dental Plans offer rate stability

- We work hard to keep rates consistent year after year to help you manage your budget.
- Our rates don't include hidden fees or set-up charges. So you know exactly what to expect from enrollment to claims processing.

We design our plans to fit any budget

- Our plans are easy to use and designed to fit any budget — employers can offer quality dental and vision benefits at an affordable cost.
- We specialize in dental benefits. Our rates reflect the true cost of the plan — no cost shifting to other lines of coverage.

We keep it simple — from setup to claims to customer service

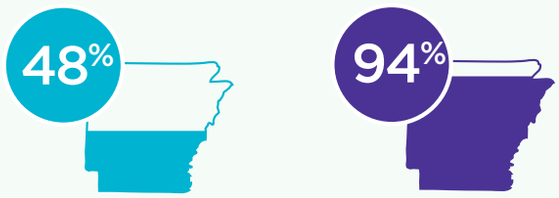
- With the largest network of dental and eye care providers in Arkansas, we make it easy for employees to find a dentist or eye doctor.
- Our member self-service tools answer the most common questions, so business owners don't have to.
- Claims are processed fast and accurately.

Your mouth says a lot about your health

Protecting your employees' smiles is good for business. Good dental health means less dentist visits and missed time at work. But we don't stop at healthy — we give you and your employees a lot to smile about when it comes to choice, care and savings.

Choice

Delta Dental offers the advantage of our dual network, one of the largest in the state and part of the Dental Dental national network. Our **PPO network** includes 48% of Arkansas dentists and offers the deepest discounts on covered services. Our **Premier network**, which also offers significant discounts, includes 94% of Arkansas dentists, giving employees the greatest access to care. The **Delta Dental National network** offers members the nation's largest network of dentists with more than 148,000 dentists and specialist at over 315,000 locations in all 50 states at 315,000 locations — and growing.[A]



PPO NETWORK **PREMIER NETWORK**

Care

All Delta Dental small business dental plans offer:

- 100% in-network coverage for exams, cleanings and X-rays, 2 times per year for every member
- No waiting periods for any services
- Composite (tooth-colored) fillings
- Orthodontics for children to age 19
- Sealants and fluoride treatments for children
- Dental implants
- Coverage for dependents up to 26 years old

Savings

Not only do our networks provide great choices, they also provide deep discounts for covered dental services. **On average, we save our members 23% on covered dental services[A]**

A. Delta Dental of Arkansas internal data (July 2019)

COVERED ON ALL PLANS

☑ Composite (tooth-colored) fillings on any tooth
☑ Orthodontics for kids
☑ Dental implants

NO WAITING PERIODS FOR ANY SERVICES

	Delta 1000	Delta 1500	Delta 2000	Delta 2500
Annual maximum (per person)	$1,000	$1,500	$2,000	$2,500
Deductible (per person / family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Carryover benefit	Included	Included	Included	Included
Waiting periods	No waiting periods for any services			
Delta Dental network	Delta Dental PPO + Premier			
DIAGNOSTIC AND PREVENTIVE[B] (Not subject to deductible)				
Cleanings, exams and X-rays	100%	100%	100%	100%
Sealants	100%	100%	100%	100%
Brush biopsy	100%	100%	100%	100%
Periodontal maintenance	100%	100%	100%	100%
BASIC SERVICES[B]				
Fillings (amalgam & composite)	80%	80%	80%	80%
Emergency palliative treatment	80%	80%	80%	80%
Minor restorative services	80%	80%	80%	80%
Other basic services	80%	80%	80%	80%
MAJOR SERVICES[B]				
Endodontics (root canal therapy)	50%	80%	80%	80%
Oral surgery	50%	80%	80%	80%
Periodontics (surgical & non-surgical)	50%	50%	80%	80%
Crowns	50%	50%	50%	50%
Prosthodontics (bridges, implants & dentures)	50%	50%	50%	50%
Relines and repairs	50%	50%	50%	50%
Orthodontia (children under 19)	50% $1,000 lifetime max	50% $1,000 lifetime max	50% $1,000 lifetime max	50% $1,500 lifetime max
MONTHLY RATES (VALID THROUGH DECEMBER 31, 2021)[C]				
Employee Only	$28.52	$31.70	$34.88	$40.22
Employee & Spouse	$57.04	$63.40	$69.76	$80.44
Employee & Child(ren)	$62.52	$67.98	$77.60	$91.70
Family	$97.58	$106.60	$120.80	$141.90

B. In-network reimbursement rates are displayed. Out-of-network reimbursement rates are 10% less than in-network reimbursement rates.
C. Small groups cannot consist entirely of immediate family members who would otherwise be eligible for an employee-spouse, employee-children, or family policy and should be enrolled as eligible dependents of the subscriber.

DeltaVision® plans are superior for a reason

SuperiorVision™

Delivering Superior Choice

Through our partnership with Superior Vision, DeltaVision members have access to a nationwide network of easy to find eye care providers.

More Eye Care Providers

More than 60,000 eye care providers nationwide.

More Options

Members can get eye exams at one place and buy eyewear at another for greater selection.

More Freedom

There are no restrictions on eyeglass frames or contact lenses. Members are free to choose from any brand, lens type and price point.

DeltaVision makes providing vision benefits easy and affordable. Our vision plans are built for greater choices, better health and ultimate business value.

In-network national retailers include

Walmart Vision Center

Sam's Club Optical

JCPenney | optical

Pearle Vision

LensCrafters

Plus online in-network options

contactsdirect

BENEFIT FREQUENCY	DeltaVision 100	DeltaVision 130	DeltaVision 150	
			Plan Option 1	Plan Option 2
Eye Exam	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Lenses	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Frames	Every 24 months	Every 24 months	Every 24 months	Every 12 months
Contact Lens Fitting Exam	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Contact Lenses	Every 12 months	Every 12 months	Every 12 months	Every 12 months
IN-NETWORK COPAYMENTS				
Eye Exam	$10	$10	$10	$10
Frames and/or Lenses (no copay for contacts)	$25	$25	$25	$10
Contact Lens Fitting Exam	$25	$25	$25	$10
IN-NETWORK BENEFITS				
Eye Exam	Covered in full after copay			
Standard Lenses (per pair)				
Single Vision	Covered in full after copay[5]			
Bifocal	Covered in full after copay[5]			
Trifocal	Covered in full after copay[5]			
Lenticular	Covered in full after copay[5]			
Progressive Lens Upgrade	See description[6]			
Frames	$100 retail allowance after copay[5]	$130 retail allowance after copay[5]	$150 retail allowance after copay[5]	$150 retail allowance after copay[5]
Contact Lens Fitting (CLF) Exam				
Standard CLF Exam[7]	Covered in full after copay			
Specialty CLF Exam[7]	$50 retail allowance after copay			
Contact Lenses[8]				
Elective (Conventional or Disposable)	$100 retail allowance	$130 retail allowance	$150 retail allowance	$150 retail allowance
Medically Necessary[9]	Covered in full			
DISCOUNTS[10]				
Insured Materials				
Frames	20% off amount over allowance			
Lens Options (scratch coat, UV coat, etc.)	20% off retail (premium options) or out-of-pocket maximums[11] (standard options)			
Progressives	20% off amount over retail lined trifocal lenses[12]			
Additional Services				
Exams, Frames & Prescription Lenses	30% off retail			
Lens Options & Contacts	20% off retail			
Disposable Contacts	10% off retail			
Refractive Surgery (LASIK)	15% — 50% off retail			
MONTHLY RATES (VALID THROUGH DECEMBER 31, 2021)[A]				
Employee Only	$6.98	$7.47	$7.82	$9.09
Employee & Spouse	$12.59	$13.46	$14.06	$16.35
Employee & Child(ren)	$13.64	$14.58	$15.25	$17.72
Family	$18.87	$20.18	$21.09	$24.54

A. Small groups cannot consist entirely of immediate family members who would otherwise be eligible for an employee-spouse, employee-children, or family policy and should be enrolled as Eligible Dependents of the Subscriber.

Seeing is believing

DeltaVision® is a smart, affordable way for your employees to keep an eye on their vision — and their overall health.

80%

The amount of information our brain receives through our eyes[3]

$48 BILLION

in productivity is lost annually due to vision disorders[4]

7 MILLION

The number of people with undiagnosed diabetes[3]

See yourself healthy

Many simple vision problems go undiagnosed — problems that could be detected by an eye exam and easily corrected.

Keeping an eye out for you

When employees with a DeltaVision plan see their eye care provider, they can get tips and solutions for common vision and eye issues, including:

- Computer Vision Syndrome
- UV protection of corneas and retinas
- Eye safety (work and play)
- Impact of glare on your eyes
- The effect of standard medications on eyesight

Allow us to open your eyes

Some systemic diseases and health conditions can also be diagnosed through a comprehensive eye exam, including:

- Diabetes
- Glaucoma
- High blood pressure
- Macular degeneration

Early detection can help lessen some of the long-term effects and help preserve vision.

Simple, hassle-free benefits administration

We know you wear a lot of hats as a small business owner, including benefits administrator and human resources executive.

But choosing and administering dental benefits shouldn't be your full-time job. We're here to make dental and vision plans hassle-free so you can focus on what really matters to you – your business, your customers and your employees.

Convenience

Better for your business

- One group application
- Simple enrollment and implementation with one dedicated account manager
- Online Employer Toolkit
  - Enroll employees
  - Review and manage dental and vision benefits
  - Review and pay monthly premium bills

Better for your employees

- One ID card for dental and vision benefits
- Customer service representatives available from 7 am – 7 pm CT
- Online Member Toolkit and Mobile App
  - Find a dentist
  - Schedule appointments (mobile app only)
  - Get cost estimates on dental services
  - Review claims and benefits
  - Oral health risk assessment

In 2019, Delta Dental of Arkansas processed more than

3,000,000 CLAIMS with **99.51%** ACCURACY

3 easy steps to get your new Delta Dental benefits.

1

Complete the Delta Dental Master Application

Use the Master Application to provide Delta Dental with details about your business. The Master Application will become part of your contract with Delta Dental, so please complete it in its entirety.

To use our Employer Toolkit to update employee eligibility, plus receive and pay bills online, complete the Employer Toolkit Access Request form.

2

Provide employee enrollment details

You have two options to provide employee enrollment information.

First, have each employee complete a paper enrollment form and submit all to us.

Second, provide enrollment details via spreadsheet. We will provide you with an Excel file for this option.

3

Pay the first month's premium

Mail a check for the first month's premium to the address below. This check is due by the effective date of coverage.

Delta Dental of Arkansas
Attn: Sales & Account Management
P.O. Box 15965
North Little Rock, AR 72231

What happens next?

When your Master Application and enrollment details are received in our office, we'll send an email confirming receipt. A second email will be sent when we've completed setting up your business as our newest client. Finally, you'll receive a third email on the coverage effective date of your benefits introducing your Delta Dental Account Manager.

Questions? Please contact:

Danielle Collie, Account Executive at (501) 992-1628 or email dcollie@deltadentalar.com

Arkansas' #1 Dental & Vision Benefits Company[D]

Welcome to the Delta Dental family!

D. Delta Dental of Arkansas Survey of independent insurance agents and business owners in Arkansas (July 2017)

1. Small Business Profiles for the State and Territories, Small Business Administration, February 2015
2. 2017 State of Small Business Report, http://www.waspbarcode.com/small-business-report
3. American Optometric Association 2014.
4. NORC at the University of Chicago, June 11, 2013, Cost of Vision Problems: The Economic Burden of Vision Loss and Eye Disorders in the United States.
5. Copay applies one time to eyeglass frame and/or lenses.
6. Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable copay, less any applicable discounts.
7. Contact Lens Fitting Exam has its own copay and is separate from the eye exam copay. Standard Contact Lens Fitting Exam applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty Contact Lens Fitting Exam applies to new contact wearers and/or a participant, who wears toric, gas permeable, or multi-focal lenses.
8. Contact lenses are in lieu of eyeglass frame and lenses benefit.
9. Medically necessary contact lenses are those prescribed for extreme visual acuity or other functional problems not treatable by eyeglass lenses. Prior authorization required.
10. The discount features are not insurance. All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. Discounts are subject to change without notice and do not apply if prohibited by the manufacturer. Discounts may vary by provider and location. Members should confirm a provider participates in offering discounts before receiving services, as not all providers offer discounts.
11. Out-of-pocket maximums apply to certain standard options on standard plastic single vision lenses and standard lined bifocal and trifocal lenses.
12. Discount over retail lined trifocal lens, including lens options.

DeltaDentalAR.com

DELTA DENTAL®

REQUESTED COVERAGE EFFECTIVE DATE

_____ / _____ / _____
MM / DD / YY

Master Application & Agreement for Business Clients

SECTION 1 — YOUR BUSINESS			
Business Name:			
Physical Address:	City:	State:	ZIP:
Mailing Address:	City:	State:	ZIP:
Telephone:	FAX:	Tax Identification Number:	
Type of Business:	NAICS / SIC Code:		

SECTION 2 — BUSINESS CONTACTS (Please provide contact information for the following people at your business.)	
Business Owner/Executive:	Title:
Telephone:	Email:
The Business Owner/Executive list above is the person who is authorized to sign this contract and agreement, grant access to employee Private Health Information (PHI), and review plan renewal information.	
Daily Contact for general questions:	
Telephone:	Email:
Billing Contact:	
Telephone:	Email:
Mailing Contact:	
Telephone:	Email:

SECTION 3 — EMPLOYEE ELIGIBILITY
How many hours per week must an employee work to be considered full-time and eligible for benefits?
How many full-time, benefits eligible employees are at your business?
Does your business require separate locations or groups for benefits? ☐ Yes ☐ No
If yes, please provide a list of the locations or groups. NOTE: Enrollment details for each employee MUST indicate the location or group in which the employee is to be included.
When is a new employee eligible for coverage?: First of the month after: ☐ Date of hire ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other
How many employees have enrolled in your new Delta Dental benefits? ☐ Dental: ☐ Vision:

SECTION 4 — YOUR DELTA DENTAL BENEFITS

Which Delta Dental benefits has your business selected? (attach copy of your proposal if you received one)	☐ Dental Plan Name:
	☐ Vision Plan Name:

List employer contribution (percentage) for your Delta Dental benefits. If none, list 0%. Dental: Vision:

Is your Delta Dental plan replacing an existing: Dental plan? ☐ Yes ☐ No Vision plan? ☐ Yes ☐ No

If yes, please provide the name of your prior Dental insurance carrier.

If yes, please provide the name of your prior Vision insurance carrier.

Will Delta Dental be expected to give credit toward the deductible and annual maximum from your prior insurance carrier?

☐ Yes ☐ No ☐ N/A If yes, we require you to include a report from the prior carrier with this application/agreement to provide this credit.

If this plan is replacing an existing dental plan, a copy of the prior dental benefits must be provided by the previous carrier to receive credit for prior comparable coverage.

Requested Effective Date (MM/DD/YYYY):

Requested Contract Renewal Date (MM/DD/YYYY):

Approved Contract Renewal Date (MM/DD/YYYY): (To be completed by Delta Dental)

SECTION 5 — ENROLLMENT OF PLAN BENEFITS

Please select one of the enrollment options below. If no option is selected, your plan benefits will default to "Option 1 - Annual Open Enrollment" with the renewal date of the contract being the "Approved Contract Renewal Date" listed above.

☐ **Option 1** **Annual Open Enrollment**	If an employee waives coverage at time of eligibility, the employee will only be able to enroll during your business's annual open enrollment period. There will be no waiting periods for enrollment or changes made during the annual open enrollment period. **OPEN ENROLLMENT Changes effective on the 1st of _____ (month)**
☐ **Option 2** **Late Entry Provision**	If an employee waives coverage at time of eligibility, the employee may enroll in any month of the year, but will have a 12 month waiting period for major services and orthodontia (as applicable).

How will the initial enrollment choices made by your employees be provided to Delta Dental?

☐ Paper Enrollment Forms

☐ Electronic File (e.g., CSV, Excel, 834 file)

Please complete the table below for each of your Delta Dental benefits.

Coverage Level	Delta Dental Dental Insurance		Delta Dental Vision Insurance	
	# of Employees Enrolled	Monthly Premium Rate	# of Employees Enrolled	Monthly Premium Rate
Employee Only				
Employee + Spouse OR Employee + 1				
Employee + Child(ren)				
Family				

SECTION 6 — PAYMENT OPTIONS

Please select your preferred method for receiving your monthly premium bills. ☐ USPS Mail ☐ Online

*If "Online" is selected, please complete the form titled "Employer Toolkit Authorization Request."

The group policy, enrollee certificate of coverage, and general information on Delta Dental benefits will be sent via email and posted to our Employer Toolkit unless otherwise noted in the "Special Instructions from your business to Delta Dental" section below.

SECTION 7 — THE LEGAL STUFF

Signing this Master Application and Agreement, you hereby acknowledge the following statements from Delta Dental Plan of Arkansas, Inc.

- ID cards will be sent to each employee's home address unless otherwise requested by your business and noted in the "Special Instructions to Delta Dental from Your Business" section below.
- Eligible dependents will be covered to the end of the month in which they turn 26 years old.
- An employee's termination date will be the end of the month, unless approved in advance and in writing by Delta Dental.

SPECIAL INSTRUCTIONS FROM YOUR BUSINESS TO DELTA DENTAL

On behalf of the business identified above, the undersigned duly authorized representative hereby certifies that the information, terms and provisions in this Master Application and Agreement are complete, true and correct. The undersigned agrees that submission of this Master Application and Agreement containing a false statement, material misrepresentation, or omission may constitute insurance fraud and may result in termination of coverage from the effective date of the Master Application and Agreement. The undersigned further agrees that in making this Application, the business agrees to the terms and provisions of the Group Contract to be provided by Delta Dental of Arkansas (Delta Dental) of which this Master Application and Agreement becomes a part following Delta Dental's decision to provide coverage to the business. The undersigned acknowledges that Delta Dental will consider this information along with the business's experience, enrollment data, and any other applicable information as part of the business's application to Delta Dental for coverage. Coverage or administration for the business will not be effective until the business receives approval in writing from Delta Dental and current coverage should not be cancelled prior to such approval. The business agrees that absence of written approval from Delta Dental does not imply acceptance by Delta Dental. Depending on the plan chosen by the business, there may be minimum enrollment requirements. Rates are subject to change based on final enrollment data and any plan design changes. It is agreed the business has 15 days from the date of delivery of the Group Contract to return the Group Contract to Delta Dental's corporate headquarters for cancellation of the Group Contract and a full refund. If the business exercises this cancellation right, the Group Contract will terminate on the Group Contract's original effective date as if no coverage or administrative services were ever in force, and all money received will be returned. However, if claims were incurred in this 15-day period, the business agrees to issue a refund to Delta Dental or, at Delta Dental's option, Delta Dental will reduce the amount of the refund otherwise payable to the business for all amounts paid by Delta Dental toward these claims. This Master Application and Agreement is subject to approval, refusal, or modification in accordance with Delta Dental's guidelines.

BUSINESS	DELTA DENTAL PLAN OF ARKANSAS, INC.
Executive name:	Name:
Title:	Title:
Agent:	
_____ Signature _____ Date	_____ Signature _____ Date

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Send this completed Master Application and Agreement, along with your first month's premium payment to: Delta Dental of Arkansas, Attn: Sales & Account Management, P. O. Box 15965, North Little Rock, AR 72231.

DELTA DENTAL®

Employer Toolkit Authorization Request

Use the Delta Dental Employer Toolkit to manage your Delta Dental benefits anytime, anywhere. Add new employees, change coverage, print ID cards, view bills, and even pay premiums all in one convenient, online, secure place.

BUSINESS INFORMATION	
Business Name:	
If your business requires separate locations/groups for benefits, indicate which will need to be accessed from the Employer Toolkit:	☐ All locations/groups ☐ Specific locations/groups:_____ _____

Please provide the name and email address for each person requiring access to the Employer Toolkit. For each person, also check which level of access needed for Eligibility Maintenance and/or Online Billing service. If no access is needed for either service, leave all boxes unchecked.

PRIMARY AUTHORIZED USER'S INFORMATION (LIST ADDITIONAL USERS ON THE BACK OF THIS FORM)	ELIGIBILITY MAINTENANCE		ONLINE BILLING		
	View only	View and update	View only	View & adjust	View, adjust & finalize
Name:					
Email:					

On behalf of _____, and with the authority to act on behalf of this business, I understand and consent to the following:

1. The business's monthly bill will be posted electronically to the Delta Dental Employer Toolkit. It is the business's responsibility to retrieve the bill from this online toolkit.
2. The only bill the business will receive will be the bill posted electronically to the Delta Dental Employer Toolkit.
3. The business is responsible for paying the bill no later than the 1st day of every month.
4. The business must inform Delta Dental of any changes to its authorized users and associated email addresses so Delta Dental can send the business notices regarding its bills. The business is still responsible for timely payment of its bill, regardless of such notices.

TERMS AND CONDITIONS OF USE

Delta Dental of Arkansas (Delta Dental) permits Groups to open website accounts for authorized individuals for purposes of submitting timely, accurate and complete Group enrollment data to Delta Dental on the Group's behalf. The Group, acting through its undersigned representative, certified that the users identified in this authorization are authorized to submit enrollment data to Delta Dental on the Group's behalf, and, in consideration for Delta Dental's granting access via this website account, agrees to the following conditions: (1) Delta Dental may rely on this electronically submitted enrollment data to the same extent as if submitted by non-electronic means; (2) the Group will undertake reasonable measures to safeguard account information, including usernames and passwords, and to prevent unauthorized access to the website by someone acting or purporting to act on the Group's behalf; (3) All requests to close the website account must be submitted in writing to Delta Dental via fax to (501) 992-1899, Delta Dental shall have three business days (excluding holidays) to close the website account; (4) the Group shall be solely responsible for any liability arising from the use of the website account and shall indemnify, hold harmless and defend Delta Dental against any claim arising from the Authorized User's use of the website account of the Group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws; and (5) the individual signing this a uthorization has the authority to permit the requested access and bind the Group the terms and conditions set forth above.

Business Executive Name (print):	Title:
Signature:	Date:

IF ADDITIONAL USERS ARE NOT BEING REQUESTED, PLEASE COMPLETE AND SUBMIT ONLY PAGE 1 OF THIS FORM.

BUSINESS INFORMATION					
Business Name:					
ADDITIONAL AUTHORIZED USER'S INFORMATION	ELIGIBILITY MAINTENANCE		ONLINE BILLING		
	View only	View and update	View only	View & adjust	View, adjust & finalize
Name: **Email:**					
Name: **Email:**					
Name: **Email:**					
Name: **Email:**					

Business Executive Name (print):	Title:
Signature:	Date:

Once completed, please fax the form to your Delta Dental Account Manager. Once your request is processed, each authorized user will receive two emails. The first with their username, and the second with their password. When your Delta Dental bill is ready, an email notification will be sent stating your bill is available for viewing. If you have any questions regarding your bill, please contact your Billing Auditor for assistance.

DELTA DENTAL

ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@ddpar.com
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination

☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year

Group Number: _____

Group Name: _____

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: _____ FIRST: _____ MI: ____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth / / MM DD YY

Marital Status ☐ Single ☐ Married

Sex ☐ Male ☐ Female

Date of Hire / / MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code."

Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date _____

☐ Diabetes - Date of onset _____

☐ Heart Disease - Date of onset _____

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

Dental
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

Vision
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other _____

☐ COBRA effective date _____

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Date of event _____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student

_____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	**Vision**	Add	Remove	EBD Code	Onset Date	**Last (if different)**	**First**	**MI**	**Relationship**	**Sex** M/F	**Birthdate** (MM/DD/YY)
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time**.
☐ I authorize payroll deductions.

Signature: _____ Date: _____