DELTA DENTAL

Delta Dental of Wisconsin

Fully-Insured Customer Profile

____

LEGAL BUSINESS NAME

Should the information listed below replace any information we have on file for an existing line of business? Yes No

BILLING

Payment method

ACH (**ACH authorization form** required)

Online payment or check

DENTAL EMPLOYER CONTRIBUTION AND COVERAGE TIER STRUCTURE

Select two-tier, three-tier, or four-tier and fill in employer contribution percentages.

	Two-Tier		Three-Tier		
Employer Contribution:	______ % Employee	______ % Family	______ % Employee	______ % Emp. / Dependent	______ % Emp. / Two or More Dependents

	Four-Tier			
Employer Contribution:	______ % Employee	______ % Emp. / Spouse	______ % Emp. / Children	______ % Emp. / Spouse / Children

12 month rate guarantee 24 month rate guarantee

Other ____

VISION EMPLOYER CONTRIBUTION AND COVERAGE TIER STRUCTURE

Select two-tier, three-tier, or four-tier and fill in employer contribution percentages.

	Two-Tier		Three-Tier		
Employer Contribution:	______ % Employee	______ % Family	______ % Employee	______ % Emp. / Dependent	______ % Emp. / Two or More Dependents

	Four-Tier			
Employer Contribution:	______ % Employee	______ % Emp. / Spouse	______ % Emp. / Children	______ % Emp. / Spouse / Children

Match all vision contacts and eligibility information to dental

ACCOUNT STRUCTURE

Is a break out by location or division needed for separate bills? Please indicate below all that apply:

Active

COBRA

Match existing dental or vision account structure set-up

Custom (please provide specific detail):

Please attach a separate sheet if additional space is needed.

ELIGIBILITY

Employees are eligible for coverage on:

Date of hire

First of the month following date of hire

First of the month following _______ days after date of hire

_______ days of employment after date of hire

Do you have a rehire, key employee, or any additional eligibility provisions? If so please specify language to include:

1. Rehires

2. Key Employees

3. Other

Employee terms of eligibility:

30 minimum average hours worked per week

_______ minimum average hours worked per week

Qualifying events effective date:

Date of event

First of the month following the date of the event

Termination date for employees:

Date of termination

End of the month following termination date

Termination date for dependents:

On birthdate

End of the month following birthdate

Coverage for domestic partners:

Yes

No

PLAN INFORMATION

Number of Eligible Employees

Current Health Carrier

Previous Dental Carrier

Previous Vision Carrier

How will enrollment be submitted? (please work with your DDWI contact to ensure you have the required data fields)

Enrollment forms or Excel Spreadsheet

Electronic file feed (i.e.: EDI 834)

Please list your vendor: ___________________________________

Dental ID card delivery:

Sent to employee's home

THE FOLLOWING ARE FOR FULLY INSURED WITH ≥50 ENROLLED ONLY:

Benefit accumulation period:

Contract year

Calendar year

Coverage for surgical procedures:

Medical primary, dental secondary (DDWI preferred)

Covered in dental plan only (additional cost may apply)

Some codes covered in medical plan and some codes covered in dental plan (please supply medical handbook or SPD)

Covered in medical plan only

Covered in dental plan only if excluded by medical (additional cost may apply)

COMPANY CONTACTS

Primary billing contact[1]

Name

Receive over-age dependent report[2]
(you may only select one person to receive the overage dependent report)

Title

Email

Phone number and extension

Employer website administrator[3]

Name

Receive over-age dependent report[2]
(you may only select one person to receive the overage dependent report)

Title

Email

Phone number and extension

Additional contact

Name

Receive over-age dependent report[2]
(you may only select one person to receive the overage dependent report)

Title

Email

Phone number and extension

[1]Your bill will be available via the Employer Portal (registration required)

[2]A report can be provided indicating dependents that are aging off plan (monthly report, reports are generated by end of the second week of the month for the following month)

[3]Responsible for adding or deleting authorized users for the employer website (registration required at **www.deltadentalwi.com/employer**)