Whether you’re purchasing group dental insurance for the first time or looking for a new plan, it’s hard to know which path to choose. Let us expertly guide you through the process.

A plan that puts you on the right path
- For groups with 2-99 employees.
- Offered on a contributory or voluntary basis.
- Two-year rates available for price stability.

Comprehensive benefits
- 100% coverage of preventive care with no waiting periods.
- Strong coverage for basic and major services.
- Optional child and/or adult orthodontic coverage available.
- Generous calendar-year maximums up to $3,000 and choice of low deductibles.

See any dentist or specialist
- Receive the strongest coverage and greatest savings at Delta Dental PPO network dentists.
- When seeing Delta Dental Premier network dentists, savings remain strong, but some coverage amounts are less than at Delta Dental PPO network dentists. When seeing non-network dentists, coverage is the same as the Delta Dental Premier network, although balance billing applies.

Advantages to seeing a network dentist include:

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No paperwork – Network dentists bill us, and we pay them directly. Members choosing non-network dentists may have to submit their own claims.

Two of the largest networks in the state
- The Delta Dental PPO network is one of the largest PPO networks statewide.
- Delta Dental Premier is one of the state’s largest networks overall, with 74% of North Dakota dentists participating.

Unsurpassed service
- Direct Benefits is there for you every step of the way, from pre-enrollment through implementation and beyond.
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Learn more about the Pathfinder Plan
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<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION</th>
<th>Delta Dental PPO Network</th>
<th>Delta Dental Premier® Network</th>
<th>Non-Delta Dental Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Services no waiting period</td>
<td>Oral evaluations/check-ups, X-rays, dental cleanings, fluoride treatments</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services no waiting period</td>
<td>Basic Restorative Care &amp; Services: amalgam (silver) fillings, sealants, space maintainers, palliative treatment for emergencies</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Coverage for Composite Resin (white) Fillings as Basic Services: Optional with 5% premium increase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coverage of Endodontic and Periodontal as Basic Services: Optional with 5% premium increase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services 6-month waiting period</td>
<td>Oral Surgery Services: basic extraction of erupted tooth or exposed root, surgical removal of erupted tooth, impacted teeth and tooth roots</td>
<td>55%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Complex or Major Services 12-month waiting period</td>
<td>Endodontic Services: pulpal therapy, root canal therapy, pulpotomy</td>
<td>55%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Periodontal Services: non-surgical and surgical periodontal care</td>
<td>55%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Restorative Care Services: posterior composite resins, inlays optional treatment ▲</td>
<td>optional treatment ▲</td>
<td>optional treatment ▲</td>
<td>optional treatment ▲</td>
</tr>
<tr>
<td></td>
<td>onlays, crowns and crown repairs(*)</td>
<td>55%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Prosthetic Services: removable prosthetic services–dentures and partials (<em>) (**), fixed prosthetic services–bridges (</em>) (**), repairs–removable and fixed</td>
<td>55%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Implants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics–optional</td>
<td>12-month waiting period. No deductible applies. 50% coverage up to $1,000, $1,500 or $2,000 lifetime maximum. Orthodontic coverage for dependent children ages 8 through 18. Available for groups of 5+ enrolled employees. Adult orthodontics available for groups of 10+ enrolled employees — 12-month waiting period, 50% coverage up to $1,000 lifetime maximum.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>Employer chooses: $0/0, $25/75, or $50/150 per person/family per calendar year for basic and major services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual plan maximum</td>
<td>$1,000 per person/per calendar year. Options available for $1,250, $1,500, $2,000, $2,500 and $3,000 maximums.</td>
<td></td>
<td></td>
<td></td>
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</table>

▲ Optional Treatment–Member receives the amalgam benefit for the least costly commonly performed course of treatment.

* Coverage does not include the following crown or bridge services: buildups, pins, posts and cores.

** Missing-tooth exclusion applies during the first 24 months of coverage.

See underwriting guidelines for explanation of takeover benefits.

Claim payments are subject to review. We strongly recommend a pre-estimate for implants and all major services.

This is a summary only. For complete details, refer to your Dental Benefit Plan Summary.

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The Pathfinder Value Plan incorporates the great features found in our Pathfinder Plan, but designed for maximum cost-effectiveness by balancing a slightly larger up-front lifetime deductible with strong coverage at extremely competitive rates.

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## PATHFINDER VALUE PLAN

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<td></td>
<td></td>
</tr>
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<td><strong>Deductible</strong></td>
<td>$100 per person (lifetime)</td>
<td></td>
<td></td>
<td></td>
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Administered and Underwritten by Delta Dental of Minnesota
GROUP PARTICIPATION REQUIREMENTS

Participation guidelines apply according to the number of employees enrolling.

For groups with 2-4 employees enrolled:
- One-time enrollment.

For groups with 5+ employees enrolled:
- Annual open enrollment.
- To be in this sizeband, a minimum of 5 employees must enroll, and enrollment must consist of at least 20% of all eligible employees and 20% of dependents not covered by another dental plan.

Waiting Periods and Takeover Benefits:

Waiting Periods Waived for Prior Comparable Coverage

If a group has at least 12 months continuous coverage with a $100 lifetime deductible, members of the group will receive waiver of Pathfinder waiting periods, with the following exceptions: The waiver does not apply to employees/dependents who (a) were not enrolled in the group’s prior dental plan and (b) join the group or enroll for coverage after the initial Pathfinder effective date.

Credit of $100 Lifetime Deductible

If a group has at least 12 months continuous coverage with a $100 lifetime deductible, with the following exceptions: The credit does not apply to employees/dependents who (a) were not enrolled in the group’s prior dental plan or (b) join the group or enroll for coverage after the initial Pathfinder effective date.

UNDERWRITING GUIDELINES

- Employee-only plans are available for all groups.
- If coverage is waived, a qualifying event must occur to gain coverage unless there is an open enrollment.
- Dual option plan offerings are not available.
- Rates will be separate by geographical area (by employer).
- Employees who drop coverage during the year may not re-enroll at anytime unless a qualifying event occurs.
- Groups with more than 50% of eligible employees residing outside Minnesota, Nebraska or North Dakota are subject to underwriting review.
- Standard coordination of benefits applies.
- If the group has less than 2 employees enrolled at the time of renewal, the group will be terminated.
- Deductibles and annual maximums are on a calendar-year basis (January through December).
- No off-contract changes are allowed.
- Dental offices and groups with high turnover or seasonal employment practices are not eligible for coverage.
- Coverage is available to family-related groups with 50% or more employees who are related by blood relation, marriage, or adoption.
- If 5 or more employees are eligible, but less than 5 are enrolling, we calculate rates according to the 2-4 employee sizeband. Participation guidelines apply according to the number of employees enrolling.

ELIGIBLE EMPLOYEE PARTICIPATION REQUIREMENTS

- If coverage is initially waived, a qualifying event must occur to gain coverage.
- No open enrollment for groups of 2-4 employees and no late enrollees, unless the employee has a change of status or qualifying event.
- If an eligible employee drops coverage, he/she may not re-enroll at anytime unless a qualifying event occurs.

Eligible Employee

- Defined as actively at work for a minimum of 20 hours per week on a regular basis.
- Full-time employees on a seasonal or temporary basis are not eligible.
- Active employees age 65+ may be enrolled the same as any other eligible employee.

Eligible Dependents

- Spouses of eligible employees.
- Dependent children to age 26 are eligible for coverage. If a dependent child is disabled prior to age 26, they remain eligible for coverage after age 26.
- Spouses — Both Employees of Same Employer Group
  - Spouses who are both employees of the same employer may each enroll in only one contract.
  - Neither spouse may be enrolled on both an individual and a family or employee plus spouse contract.
  - Both are eligible to be enrolled on separate individual “employee-only” contracts.

Eligible Retirees

- Retirees are eligible for coverage provided they had dental coverage with another carrier in a takeover situation at the time of retirement and elected to continue coverage.
- Retirees are not covered in the following situations:
  - If the retiree was not covered at the time of retirement, or they were not already covered as a retiree by another carrier in a takeover situation.
  - If the retiree drops their coverage, they may not re-enroll at a later date.
  - Retirees may not add dependents to their coverage who were not already covered as a retiree by another carrier in a takeover situation.

Domestic Partners

- Groups of any size may request domestic partners coverage (same-sex and/or opposite sex).

ORTHODONTICS — OPTIONAL ADD-ON

Children
- Child orthodontic option available as an add-on for groups of 5 or more enrolled employees.
- 12-month waiting period for new groups without prior comparable orthodontic coverage, and for new employees/enrollees.
- Coverage for dependent children ages 8 through 18.
- Coverage for limited, interceptive, and comprehensive orthodontic treatment.
- 50% coverage up to $1,000, $1,500, or $2,000 lifetime maximum.

Adults
- Adult orthodontics available for groups of 10 or more enrolled employees.
- 12-month waiting period for new groups without prior comparable orthodontic coverage, and for new employees/enrollees.
- Coverage for limited, interceptive, and comprehensive orthodontic treatment.
- 50% coverage up to $1,000 lifetime maximum.
## Pathfinder Plan

Rates guaranteed for 12 months after issue. Rates Effective January 1, 2014.

<table>
<thead>
<tr>
<th>ZIP code area</th>
<th>5+ Employees Enrolled</th>
<th>2-4 Employees Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly premium no ortho</td>
<td>Monthly premium with ortho*</td>
</tr>
<tr>
<td></td>
<td>$0/$0</td>
<td>$25/$75</td>
</tr>
<tr>
<td>581</td>
<td>Employee</td>
<td>$31.80</td>
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<tr>
<td></td>
<td>Employee + Spouse</td>
<td>$64.80</td>
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<td></td>
<td>Employee + Child(ren)</td>
<td>$70.15</td>
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<tr>
<td></td>
<td>Family — Employee, Spouse, Child(ren)</td>
<td>$106.60</td>
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<tr>
<td></td>
<td>Employee</td>
<td>$29.75</td>
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<tr>
<td></td>
<td>Employee + Spouse</td>
<td>$60.75</td>
</tr>
<tr>
<td></td>
<td>Employee + Child(ren)</td>
<td>$65.75</td>
</tr>
<tr>
<td></td>
<td>Family — Employee, Spouse, Child(ren)</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

### Additional Information

**Orthodontia coverage is for children ages 8 through 18 only, available only for groups of 5 or more enrolled employees.**

## Pathfinder Value Plan

Rates guaranteed for 12 months after issue. Rates Effective January 1, 2014.

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<td>Monthly premium with ortho*</td>
</tr>
<tr>
<td></td>
<td>$0/$0</td>
<td>$25/$75</td>
</tr>
<tr>
<td>581</td>
<td>Employee</td>
<td>$27.75</td>
</tr>
<tr>
<td></td>
<td>Employee + Spouse</td>
<td>$56.65</td>
</tr>
<tr>
<td></td>
<td>Employee + Child(ren)</td>
<td>$61.35</td>
</tr>
<tr>
<td></td>
<td>Family — Employee, Spouse, Child(ren)</td>
<td>$93.25</td>
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<tr>
<td></td>
<td>Employee</td>
<td>$26.05</td>
</tr>
<tr>
<td></td>
<td>Employee + Spouse</td>
<td>$53.15</td>
</tr>
<tr>
<td></td>
<td>Employee + Child(ren)</td>
<td>$57.55</td>
</tr>
<tr>
<td></td>
<td>Family — Employee, Spouse, Child(ren)</td>
<td>$87.45</td>
</tr>
</tbody>
</table>

### Additional Information

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---

**Plan Options**

<table>
<thead>
<tr>
<th>Plan Options</th>
<th>Rate Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,750 annual maximum</td>
<td>+5%</td>
</tr>
<tr>
<td>$4,500 annual maximum</td>
<td>+9%</td>
</tr>
<tr>
<td>$2,000 annual maximum**</td>
<td>+19%</td>
</tr>
<tr>
<td>$2,500 annual maximum**</td>
<td>+23%</td>
</tr>
<tr>
<td>$3,000 annual maximum**</td>
<td>+26%</td>
</tr>
<tr>
<td>2-year rates</td>
<td>+3%</td>
</tr>
<tr>
<td>Increase coverage for composite resin (white) fillings to 80%</td>
<td>+5%</td>
</tr>
<tr>
<td>Increase Endodontics/Periodontal coinsurance to 80%</td>
<td>+5%</td>
</tr>
<tr>
<td>Less than 60% employee participation</td>
<td>+10%</td>
</tr>
<tr>
<td>Family-related groups</td>
<td>+12%</td>
</tr>
<tr>
<td>$5,500 orthodontic lifetime maximum* (groups must have an annual plan maximum of $1,500 or greater)</td>
<td>+$2.75 to monthly premium w/ortho for Employee + Child(ren) and Family rates</td>
</tr>
<tr>
<td>$2,000 orthodontic lifetime maximum* (groups must have an annual plan maximum of $2,000 or greater)</td>
<td>+$4.75 to monthly premium w/ortho for Employee + Child(ren) and Family rates</td>
</tr>
<tr>
<td>Adult orthodontics (available for groups of 10+, $1,000 lifetime maximum, 12-month waiting period)</td>
<td>EE — $3.80 • EE+Spouse — $7.60 • EE+Child(ren) — $5.05 • Family — $9.20</td>
</tr>
<tr>
<td>Remove waiting period</td>
<td>+11%</td>
</tr>
</tbody>
</table>

**Available for groups of 5+ with participation of 60% or greater**

---

For current rates, please contact Direct Benefits Inc. at 651-649-3503 or (toll-free) 800-620-5010. The Pathfinder Plan is offered exclusively by Direct Benefits Inc. and administered and underwritten by Delta Dental of Minnesota, 500 Washington Ave. S., Minneapolis, MN 55415.

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Delta Dental PPO Plus Premier – Pathfinder Plan
Master Dental Contract Application

PART A - COMPANY INFORMATION

Legal Company Name ___________________________________________

Address ______________________________________________________ Phone (___)

City __________________________ State _______ Zip Code ___________

Type of Coverage:  □ Employee Only    □ Employee and Dependents

Plan Effective Date: ____________________________________________ Other _______________________

Eligibility probationary period for new employees:  First of month following ________________ Other _______________________

Does your company currently have a dental plan?  □ No  □ Yes (name of carrier) _______________________

(Attach a copy of current billing statement and benefit summary) Length of coverage: _______________________

Waiting Periods and Takeover Benefits:

Waiting Periods Waived for Prior Comparable Coverage
If a group has at least 12 continuous months of prior comparable employer paid coverage, and no gap between that coverage and the Pathfinder effective date, all members of the group will receive a waiver of Pathfinder waiting periods, with the following exceptions: The waiver does not apply to employees/dependents who join the group or enroll for Pathfinder coverage after the initial Pathfinder effective date.

Credit of $100 Lifetime Deductible
If a group has at least 12 continuous months of coverage with a $100 lifetime deductible on its prior dental plan and converts to a Pathfinder plan with a $100 lifetime deductible, members of the group will receive credit for the $100 deductible with the following exceptions: The credit does not apply to employees/dependents who (a) were not enrolled in the group’s prior dental plan or (b) join the group or enroll for coverage after the initial Pathfinder effective date.

PART B - PARTICIPATION

TOTAL NUMBER OF ELIGIBLE EMPLOYEES ______________________

Please check (✓) one below

□ 2-4 Employees Enrolled:  One-Time Enrollment – Greater of 2 employees enrolled or 20% of eligible employees and dependents enrolled not covered elsewhere.

□ 5-99 Employees Enrolled:  Annual Open Enrollment – Greater of 5 employees enrolled or 20% of eligible employees and dependents not covered elsewhere.

□ Voluntary Program (Pathfinder Flex Plan):  Annual Open Enrollment – Group must have 5 or more eligible employees. A minimum of 5 employees must enroll.

□ MEDICAL LOCK (INCLUDE A COPY OF MOST RECENT MEDICAL BILLING STATEMENT)
PART C – DENTAL PROGRAM (choose one):

All programs require completion of a Pathfinder Plan Enrollment Form

- **Pathfinder Plan**
  - Lifetime Deductible: $50 per person, Diagnostic & Preventive Services only
  
  **Annual Plan Deductible for Basic and Major Services only:**
  - Please check (✓) one below
  - $0/$0 Single/Family  
  - $25/$75 Single/Family

- **Pathfinder Value Plan**
  - Lifetime Deductible: $100 per person, applies to all services

  **Annual Maximum: Please check (✓) one below**
  - $1,000 per person/per calendar year  
  - $1,500 per person/per calendar year

Increase coverage for Endodontic and Periodontal services to 80%  
- Yes  
- No

- Is employee participation 60% or greater?  
- Yes  
- No

- Is group 50% or more related by blood, marriage or adoption?  
- Yes  
- No

- Waive waiting period?  
- Yes  
- No

---

- **Pathfinder Flex Plan**
  
  **Annual Plan Deductible for Basic and Major Services only:**
  - $50/$150 Single/Family

  **Annual Maximum: Please check (✓) one below**
  - $1,000 per person/per calendar year  
  - $2,000 per person/per calendar year

  Is employee contribution 50% or greater?  
  - Yes  
  - No

  Is group 50% or more related by blood, marriage or adoption?  
  - Yes  
  - No

---

<table>
<thead>
<tr>
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<th>Single</th>
<th>Family</th>
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</thead>
<tbody>
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Please Note: If five or more employees are eligible, but less than five are enrolling, rates and participation guidelines for the number enrolled apply.

<table>
<thead>
<tr>
<th>Rates Sold - Pathfinder Flex Plan</th>
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<tbody>
<tr>
<td>5+ Eligible Employees</td>
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<tr>
<td>Single</td>
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<tr>
<td>Single +1</td>
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<tr>
<td>Family</td>
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Please Note: Minimum of five employees must enroll.

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PART D - PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS

The following certified Pediatric Dental Essential Health Benefits (EHB) Plan is available for the Pathfinder Plan and Pathfinder Value Plan:

- Pediatric Dental EHB Dental Group Plan A (to age 19)

PART E - ORTHODONTICS

Does the prior dental plan have orthodontic coverage?  
- Yes  
- No

- **Child Orthodontics** (For Pathfinder Plan and Pathfinder Value Plan groups with 5 or more enrolled employees; Pathfinder Flex Plan groups with 10 or more enrolled employees):
  - $1,000 Lifetime Orthodontic Maximum
  - $1,500 Lifetime Orthodontic Maximum
  - $2,000 Lifetime Orthodontic Maximum

- **Adult Orthodontics** (For Pathfinder Plan and Pathfinder Value Plan groups with 10 or more enrolled employees):
  - $1,000 Lifetime Orthodontic Maximum

Please Note: If you are adding orthodontics and the previous dental plan did not have prior, comparable orthodontic coverage, there will be a 12-month waiting period for orthodontic benefits under all Pathfinder plans.
AGENT OF RECORD (if any) Completion of all fields required

Name ___________________________ Agency ___________________________
Address __________________________ Phone ( ) ___________________________
City ___________________________ State ___________ Zip Code ___________
E-mail ___________________________ Address ___________________________

Agent Signature / Insurance License ID Number ___________________________

Tax ID Number
Note: Commissions will be paid to this TIN.

PREMIUM REMITTANCE

The first month’s premium must accompany the application. Thereafter, Delta Dental must receive the appropriate remittance on the first of each month.

Instructions:
2. Each eligible employee must complete and sign a Pathfinder Plan Membership Enrollment Form or Pathfinder Dental Flex Plan Membership Enrollment Form; or be identified on an approved Enrollment spreadsheet completed by Group Administrator.
3. Send the original Delta Dental PPO Plus Premier – Pathfinder Plan Master Dental Contract Application, completed Pathfinder Plan Enrollment Forms or approved Enrollment Spreadsheet, copy of corresponding Dental Proposal(s), a check for first month of premium payable to Delta Dental, along with current prior carrier billing statement and benefit summary, if applicable, to:

   Direct Benefits, Inc.
   325 Cedar Street, Suite 800
   Saint Paul, MN  55101

Please Select Payment Option:

☐ ACH Automatic Check Handling - Please note: .25% premium discount for ACH (Include ACH Authorization Form and voided check)
☐ Check ☐ Wire

For questions call (651) 649-3503 or 1-800-620-5010.

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 in Pathfinder Plan or Pathfinder Value Plan becomes less than two, the number of enrolled employees in Pathfinder Flex Plan becomes less than five or contracted participation guidelines are not met. Delta Dental has permission to contact trade and bank references, access commercial and or consumer credit reporting agencies.

Delta Dental will return a contract upon acceptance of the application. 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

_________________________________________ Title ___________________________
Signature                                      Date ___________________________

Please send all future correspondence to:

_________________________________________ Title ___________________________
Group Administrator’s Name (please print)
Phone Number ( ) Fax Number ( )
E-mail Address ___________________________

MA-PFDwEHB-Pooled v12/13
Delta Dental PPO plus Premier- Pathfinder Plan

Fully-Insured Groups

Automated Clearinghouse Authorization Agreement

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<tr>
<th>Company Name</th>
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<td>authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the <strong>Total Amount Due</strong> according to our Invoice / Statement. Premium will be taken on the first business day of each month</td>
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<th>PLEASE INCLUDE A VOIED CHECK</th>
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<th>Signature</th>
<th>Today's Date</th>
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Questions? Please call our Billing and A/R Department at: 651-406-5902 or 1-800-906-4702

Please complete this form and fax to us at: 1-877-803-2433.

or,

Please complete this form and mail to:

**Delta Dental of Minnesota**

**ATTN: Billing and Accounts Receivable**

**P.O. Box 9304**

**Minneapolis, MN 55440-9304**
Delta Dental of Minnesota

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee’s Name:

Last First Middle Initial

Social Security Number:

Gender:

Male Female

Marital Status:

Single Married Widowed Divorced Legally Separated

Date of Birth (Month-Day-Year):

Employee’s Address:

City Address

Day Phone Number Evening Phone Number

PART B – ENROLLMENT INFORMATION

Select Coverage Type – Who Is Being Enrolled – Check One Box Only

☐ Employee only* ☐ Family

☐ Employee and Spouse ☐ No Coverage * If waiving coverage for employee and/or any eligible family members, complete Part D.

PART C – DEPENDENT INFORMATION

Relationship To Employee

(Include Last Name Only if Different From Employee’s)

First Name, Middle Initial, Last Name

Gender

M F

Date of Birth Month/Day/Year

Full time Student?

Unmarried?

☐ Spouse ☐ Domestic Partner

☐ Dependent Child

☐ Dependent Child

☐ Dependent Child

PART D – OTHER INSURANCE COVERAGE – Complete if employee and/or eligible dependents are not being enrolled.

Do you (the employee) have other dental coverage? ☐ Yes ☐ No

Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: ______________________________

Policy/Identification Number: ______________________________

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract’s participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Employee Signature: ____________________________

Date: ____________________________

PART E – EMPLOYEE SIGNATURE – Sign and date form as verification of your enrollment.

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: ____________________________

Date: ____________________________

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ New Group

Hire Date: ____________________________

Prior Coverage Start Date (if applicable): __________ / _______ / _______

Coverage Effective Date: __________ / _______ / _______

☐ Existing Delta Dental Group

Hire Date: ____________________________

Prior Coverage Start Date (if applicable): __________ / _______ / _______

Coverage Effective Date: __________ / _______ / _______

☐ New Hire – Apply Probationary Period (if applicable) to determine Effective Date

Hire Date: __________ / _______ / _______

Effective Date: __________ / _______ / _______

☐ Open Enrollment Effective Date: __________ / _______ / _______

☐ Rehire Date Lay Off Began: __________ / _______ / _______

Date Rehired: __________ / _______ / _______

☐ Return from Leave of Absence

Date Leave Began: __________ / _______ / _______

Date Returned to Work: __________ / _______ / _______

☐ Employee Change Part Time to Full Time

Date of Status Change: __________ / _______ / _______

Effective Date: __________ / _______ / _______

☐ Previously Waived Coverage or Loss of Coverage

Qualifying Event Reason: ______________________________

Hire Date: __________ / _______ / _______

Event Date: __________ / _______ / _______

Effective Date: __________ / _______ / _______

Group Name: ____________________________

Group & Subgroup Numbers: ____________________________

Group Representative’s Signature: ____________________________

Date: ____________________________

Phone Number: ____________________________
Employer Instructions

- Review Parts A, B, C, D, and E to assure the employee provided complete, accurate and legible information.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).
- Delta Dental of Minnesota generally completes enrollment requests within five business days of receipt.

Complete Part F - Group Enrollment Information
- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer to Delta Dental and submitting initial employee enrollment. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies. Note: For a New Group enrolling a Direct Billed COBRA participant, write Direct Bill in the New Group section. If information is not provided, participant will not be enrolled and billed properly.
- **Existing Delta Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in your Delta Dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group’s open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Status Change** – The employee’s employment status changed and the employee is now eligible for dental benefits.
- **Previously Waived Coverage or Loss of Coverage** – If an employee waives coverage, he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage. If an employee or dependent involuntarily losses coverage and are now eligible to enroll, complete this section.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:
Delta Dental of Minnesota
Attn: Enrollment Department
PO Box 330
Minneapolis MN  55440-0330
The following is a checklist of the required materials when submitting a new Pathfinder Plan group for implementation:

1. 1st month’s premium check made payable to DELTA DENTAL

2. Completed Master Application – State specific
   - Group Name, Address & Phone Number
   - Type of coverage (available for Employees Only or Employees & dependents)
   - Effective Date of coverage
   - Probationary Period for new employees
   - Current coverage information & documentation for take-over (last billing statement and schedule of benefits)
   - Total Number of Eligible Employees & participation size-band marked
   - If Medical Lock - copy of medical billing
   - Complete all areas of Part C (Deductible, Annual Maximum, Endo/Perio coverage, Employee Participation, etc.)
   - Sold Rates (provide a copy of an agent generated quote from our website: http://www.directbenefits.com/delta-pathfinder-mn-nd-a-ne-dental)
   - Part D Orthodontics, if electing, indicate the Lifetime Maximum
   - Completed & Signed Agent of Record Section
   - Premium Remittance (ACH or Monthly Billing)
   - If electing ACH - completed & signed ACH Authorization Form & copy of a voided check
   - Group Administrator Signature & Group Correspondence contact information

3. Underwriting Guidelines
   - Required participation is being met for requested product & size band
   - If electing $2,000 Annual Max, 5+ enrolled & 60% or greater participation
   - If Orthodontics is elected, required participation is being met
   - Pathfinder Enrollment Forms

4. Enrollment forms for ALL benefit eligible employees (including waivers) Waivers must include name, marital status, address and Part D – other coverage information for employee and/or eligible dependents

If you have any questions, please contact Jessica Traiforos at 651-259-6256 or Jessica@directbenefits.com.

Submissions should be mailed to the following address:

Attn: Jessica Traiforos
Direct Benefits, Inc.
325 Cedar Street Suite 800
Saint Paul MN 55101