

 DELTA DENTAL®



DELTA DENTAL OF OKLAHOMA 

2023

SELECT

Delta Dental of Oklahoma - Select

2023

NUMBER OF ELIGIBLE EMPLOYEES: 2-99[†]

PROPOSED EFFECTIVE DATE: JANUARY – DECEMBER 2023 (1ST DAY OF SELECTED MONTH)

Delta Dental of Oklahoma – Select for employer groups is a unique approach to providing solutions to the ever-changing needs of employees. With Delta Dental – Select, employers can provide their employees the opportunity to select from the menu of plans listed below.

		Lowest Cost Plan	Lowest Cost Comprehensive Plan	Expanded Network Access	Extra Benefits
Plan Options*	Delta Dental Patient Direct Discount Program †	Delta Dental PPO – Preventive Plus	Delta Dental PPO	Delta Dental PPO – Plus Premier	Delta Dental PPO – Plus Premier “Elite”
Preventive/Diagnostic Services	Discount	100%	100%	100%	100%
Basic Services	Discount	80% **	80% **	80% **	80% **
Major Services	Discount	N/A	50% **	50% **	50% **
Orthodontic Services	Discount	N/A	50% Child Only	50% Child Only	50% Family
Per Person Deductible	N/A	\$50	\$50	\$50	\$50
Annual Maximum	N/A	\$750 Per Person	\$1,500 Per Person	\$1,500 Per Person	\$3,000 Per Person
Lifetime Orthodontic Maximum	N/A	N/A	\$1,500 Per Child	\$1,500 Per Child	\$2,000 Per Person
Additional Benefits Available	N/A	N/A	N/A	N/A	See Program of Benefits

† A minimum of two (2) Eligible Employees must be enrolled in either Delta Dental PPO – Preventive Plus, PPO, PPO – Plus Premier and/or PPO – Plus Premier “Elite” plans.

* At least one (1) Eligible Employee must be enrolled in a plan option in order for that option to be available to the group.

** Per Person Deductible Applies

† This is not an insured program.



Members enrolled in the PPO – Preventive Plus, PPO, PPO – Plus Premier and PPO – Plus Premier “Elite” plans through Delta Dental – Select also may have additional preventive benefits available to them with Health *through* Oral Wellness® (HOW®). For more information, please visit DeltaDentalOK.org/HOW

		2022 Rates Holding for 2023	2022 Rates Holding for 2023	2022 Rates Holding for 2023	2022 Rates Holding for 2023
Monthly Rates	Patient Direct	PPO – Preventive Plus	PPO	PPO – Plus Premier	PPO – Plus Premier “Elite”
Employee Only	\$5.00	\$23.00	\$ 34.00	\$ 50.00	\$ 82.00
Employee + Spouse	N/A	\$46.00	\$ 70.00	\$ 98.00	\$164.00
Employee + Child(ren)	N/A	\$57.00	\$ 86.00	\$130.00	\$213.00
Family	\$7.00	\$77.00	\$116.00	\$193.00	\$303.00

Federally Compliant Plans specifically designed to meet ACA Pediatric Dental Essential Health Benefit standards for persons to age 19 are also available to groups through Delta Dental of Oklahoma. For more information, please contact Sales@DeltaDentalOK.org.



Boost Your Benefits

Check out

HOW®



**Available to
Select plan
enrollees!**

For questions about HOW®, please contact our Customer Service team at **405-607-2100 (OKC Metro)** or **800-522-0188 (Toll Free)** or visit **[DeltaDentalOK.org/HOW](https://www.DeltaDentalOK.org/HOW)**

Delta Dental of Oklahoma is dedicated to advancing the oral wellness of our members. We recognize each member is unique, and some may need additional services in order to achieve optimal oral health.

Health through Oral Wellness® (HOW®) enhanced benefits are designed to boost members existing Delta Dental plan with additional preventive benefits, if they are at higher risk for developing caries and/or periodontal disease.*

*based on the results of the HOW® approved assessment performed in a dental office

PROGRAM OF BENEFITS: DELTA DENTAL PPO – PREVENTIVE PLUS

Delta Dental of Oklahoma's benefits consist of Diagnostic and Preventive Services, Basic Services, Major Services and Orthodontic Services. The benefits listed below are not a complete list. Limitations to benefits can be found in the Summary Plan Description.

Diagnostic and Preventive Services (Class I Benefits)

- Oral evaluation
- Routine prophylaxis, including cleaning and polishing
- Bitewing and periapical x-rays
- Full-mouth x-rays
- Space maintainers for eligible dependent children only
- Minor emergency (palliative) treatment for relief of pain
- Topical application of fluoride for eligible dependent children only
- Topical application of sealants for eligible dependent children only, limited to permanent first and second molars free of caries and restorations on the occlusal surface
- Periodontal maintenance

Note: Benefits paid by the Plan for covered oral evaluations and routine prophylaxis will not reduce your Benefit Year Maximum Payment for combined Class I and Class II covered dental services.

Basic Services (Class II Benefits)

- Amalgam and composite fillings
- Stainless steel crowns for eligible dependent children only when the natural teeth cannot be restored with another filling material
- General Anesthesia/IV Sedation – when administered by a properly licensed dentist, in the dental office, in conjunction with covered oral surgery or when necessary due to concurrent medical conditions
- Endodontics – includes pulpal therapy and root canal treatment
- Oral Surgery – extractions and other covered oral surgery procedures
- Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance procedures which is payable as a Diagnostic/Preventive Service (Class I)

Major Services (Class III Benefits)

Not applicable to this plan.

Orthodontics (Class IV Benefits)

Not applicable to this plan.

PROGRAM OF BENEFITS: DELTA DENTAL PPO

Delta Dental of Oklahoma's benefits consist of Diagnostic and Preventive Services, Basic Services, Major Services and Orthodontic Services. The benefits listed below are not a complete list. Limitations to benefits can be found in the Summary Plan Description.

Diagnostic and Preventive Services (Class I Benefits)

- Oral evaluation
- Routine prophylaxis, including cleaning and polishing
- Bitewing and periapical x-rays
- Full-mouth x-rays
- Space maintainers for eligible dependent children only
- Minor emergency (palliative) treatment for relief of pain
- Topical application of fluoride for eligible dependent children only
- Topical application of sealants for eligible dependent children only, limited to permanent first and second molars free of caries and restorations on the occlusal surface
- Periodontal maintenance

Note: Benefits paid by the Plan for covered oral evaluations and routine prophylaxis will not reduce your Benefit Year Maximum Payment for combined Class I, Class II and Class III covered dental services.

Basic Services (Class II Benefits)

- Amalgam and composite fillings
- Stainless steel crowns for eligible dependent children only when the natural teeth cannot be restored with another filling material
- General Anesthesia/IV Sedation – when administered by a properly licensed dentist, in the dental office, in conjunction with covered oral surgery or when necessary due to concurrent medical conditions
- Endodontics – includes pulpal therapy and root canal treatment
- Oral Surgery – extractions and other covered oral surgery procedures
- Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance procedures which is payable as a Diagnostic/Preventive Service (Class I)

Major Services (Class III Benefits)

- Provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material
- Prosthodontics – procedures for construction of fixed bridges, partial dentures and complete dentures
- Implants – procedures for implant placement, maintenance and repair of implants, and implant-supported prosthetics

Orthodontics (Class IV Benefits)

- The necessary treatment and procedures required for the correction of malposed teeth for dependent children only under age 26.

PROGRAM OF BENEFITS: DELTA DENTAL PPO – PLUS PREMIER

Delta Dental of Oklahoma's benefits consist of Diagnostic and Preventive Services, Basic Services, Major Services and Orthodontic Services. The benefits listed below are not a complete list. Limitations to benefits can be found in the Summary Plan Description.

Diagnostic and Preventive Services (Class I Benefits)

- Oral evaluation
- Routine prophylaxis, including cleaning and polishing
- Bitewing and periapical x-rays
- Full-mouth x-rays
- Space maintainers for eligible dependent children only
- Minor emergency (palliative) treatment for relief of pain
- Topical application of fluoride for eligible dependent children only
- Topical application of sealants for eligible dependent children only, limited to permanent first and second molars free of caries and restorations on the occlusal surface
- Periodontal maintenance

Note: Benefits paid by the Plan for covered oral evaluations and routine prophylaxis will not reduce your Benefit Year Maximum Payment for combined Class I, Class II and Class III covered dental services.

Basic Services (Class II Benefits)

- Amalgam and composite fillings
- Stainless steel crowns for eligible dependent children only when the natural teeth cannot be restored with another filling material
- General Anesthesia/IV Sedation – when administered by a properly licensed dentist, in the dental office, in conjunction with covered oral surgery or when necessary due to concurrent medical conditions
- Endodontics – includes pulpal therapy and root canal treatment
- Oral Surgery – extractions and other covered oral surgery procedures
- Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance procedures which is payable as a Diagnostic/Preventive Service (Class I)

Major Services (Class III Benefits)

- Provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material
- Prosthodontics – procedures for construction of fixed bridges, partial dentures and complete dentures
- Implants – procedures for implant placement, maintenance and repair of implants, and implant-supported prosthetics

Orthodontics (Class IV Benefits)

- The necessary treatment and procedures required for the correction of malposed teeth for dependent children only under age 26.

PROGRAM OF BENEFITS: DELTA DENTAL PPO – PLUS PREMIER “ELITE”

Delta Dental of Oklahoma’s benefits consist of Diagnostic and Preventive Services, Basic Services, Major Services and Orthodontic Services. The benefits listed below are not a complete list. Limitations to benefits can be found in the Summary Plan Description.

Diagnostic and Preventive Services (Class I Benefits)

- Oral evaluation
- **Routine prophylaxis, including cleaning and polishing and/or Periodontal maintenance (maximum combined total of four)**
- Bitewing and periapical x-rays
- Full-mouth x-rays
- Space Maintainers for eligible dependent children only
- Minor emergency (palliative) treatment for relief of pain
- Topical application of fluoride for eligible dependent children only
- Topical application of sealants for eligible dependent children only, limited to permanent first and second molars free of caries and restorations on the occlusal surface

Note: Benefits paid by the Plan for covered oral evaluations and routine prophylaxis will not reduce your Benefit Year Maximum Payment for combined Class I, Class II and Class III covered dental services.

Basic Services (Class II Benefits)

- Amalgam and composite fillings
- Stainless steel crowns for eligible dependent children only when the natural teeth cannot be restored with another filling material
- General Anesthesia/IV Sedation – when administered by a properly licensed dentist, in the dental office, in conjunction with covered oral surgery or when necessary due to concurrent medical conditions
- Endodontics – includes pulpal therapy and root canal treatment
- Oral Surgery – extractions and other covered oral surgery procedures
- Periodontics – procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance procedures which is payable as a Diagnostic/Preventive Service (Class I)
- **Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth**
- **Non-intravenous conscious sedation**
- **Inhalation of nitrous oxide/analgesia, anxiolysis**

Major Services (Class III Benefits)

- Provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material
- Prosthodontics – procedures for construction of fixed bridges, partial dentures and complete dentures
- Implants – procedures for implant placement, maintenance and repair of implants, and implant-supported prosthetics
- **Other drugs and/or medicaments, by report**
- **Application of desensitizing medicament**
- **Occlusal guard**
- **Repair or reline of the occlusal guard**
- **External bleaching tray – per arch – performed in office**

Orthodontics (Class IV Benefits)

- The necessary treatment and procedures required for the correction of malposed teeth

Orthodontic coverage is a benefit provided for the entire family.

Checklist for New Groups

2023

When enrolling in a new group, there are several key areas essential in providing a smooth implementation. To better serve our clients, we have developed a checklist to aid in the process of enrolling and setting up new groups.

- Application for Group Contract completed in its entirety and signed by the person authorized to contract for the group and producer (if applicable).
 - Step 1:** Plan Effective Date
 - Step 2:** Employer Information
 - Step 3:** Eligibility and Enrollment
 - Step 4:** Employer Contribution
 - Step 5:** Contact Information and Online Resources Access
 - Step 6:** Fully Insured Plan Options and Plan Selection
 - Step 7:** Third Party Administrators
 - Step 8:** Payment Options
 - Step 9:** Producer/Agent Information
 - Step 10:** Acknowledgement and Signatures

Please note: Incomplete or inaccurate applications may cause delays in processing time.

- Individual enrollment form completed and signed by each employee enrolling in the dental plan; enrollment may also be submitted by [electronic file](#). For more information on acceptable electronic file formats, please contact Sales@DeltaDentalOK.org.

Please mail new group submissions to:
Delta Dental of Oklahoma
Attention: Sales
P.O. Box 54709
Oklahoma City, Oklahoma 73154-1709

or send an email to:

Sales@DeltaDentalOK.org



APPLICATION FOR GROUP CONTRACT

Delta Dental of Oklahoma – *Select*

For Plan Year 2023

This Application for Group Contract is hereby made a part of the Plan Agreement and is subject to all terms and conditions of said Agreement. This Application for Group Contract will not be accepted unless **signed and completed in its entirety**.

Step 1 – PLAN EFFECTIVE DATE: (Month) _____ 01, 2023

Step 2 – EMPLOYER INFORMATION

Legal Business Name (as it should appear on Summary Plan Description and Plan Agreement)

DBA (if applicable)

Billing/Mailing Address

City

State

Zip

Physical Oklahoma Address (if different from billing/ mailing address)

City

State

Zip

Telephone Number

Nature of Business

Federal Tax ID Number

SIC Code

ERISA Exempt: No Yes (exemption typically only applies to government employers/entities or religious institutions)

Step 3 – ELIGIBILITY AND ENROLLMENT:

A minimum of two (2) enrolled Eligible Employees is required for participation in Select. At least one (1) Eligible Employee must be enrolled in a plan option in order for that option to be available to the group.

Total Number Eligible Employees: _____

Employees are eligible for coverage on (select one):

- The date of hire The first of the month following the date of hire
- The _____ day of continuous full-time employment*
- The first of the month following _____ days of continuous full-time employment*

Is the following included with this application? (select all that apply): Enrollment Forms Electronic Enrollment Data

*Cannot exceed 90 days between first day of full-time employment and coverage start date.



Step 4 – EMPLOYER CONTRIBUTION

Employer contribution to the employee cost of the plan (select one): None A portion All

Step 5 – CONTACT INFORMATION AND ONLINE RESOURCES ACCESS

Please provide a minimum of two (2) authorized group contacts. A valid email address is required for each contact as our Select product is administered electronically. Enter the information for each contact that is to receive access through Online Resources, Delta Dental of Oklahoma’s (DDOK) secure benefits administration portal for eligibility maintenance and invoice reporting and payment.

Contact Type:

- **Primary Contact** – Authorized contact for all aspects of plan administration and recipient of essential plan correspondence, including plan documents, renewals, CDT changes, billing/delinquency notices, etc.
- **Secondary Contact** – Authorized contact for plan administration and recipient of plan correspondence in the event the Primary Contact cannot be contacted
- **Executive** – Authorized contact for all aspects of plan administration; should have access to billing and eligibility online.
- **Billing** – Authorized contact for billing inquiries; should have access to view and pay invoices online
- **Eligibility** – Authorized contact for eligibility and enrollment inquiries; should have access to enrollment online as indicated (view only or modify)

Eligibility Access:

- **View only** – Contact should have read-only access to online eligibility
- **Modify** – Contact should have ability to make changes through online eligibility

Primary Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify

Secondary Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify

Additional Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify

Additional Contact	Title
Email	Telephone
Contact Type (select one): <input type="checkbox"/> Billing <input type="checkbox"/> Eligibility <input type="checkbox"/> Executive	Eligibility Access (select one): <input type="checkbox"/> View only <input type="checkbox"/> Modify

An authorized representative for the Employer approves access to information on this account for the persons named above, and to receive monthly invoice(s) via Online Resources. Furthermore, it is the responsibility of the Employer to submit written notification to Delta Dental of Oklahoma if a contact’s access to the account or Online Resources should be terminated or changed. A Group Change Form is available via Online Resources on the Documents - Forms and Links page. An authorized representative for the Employer may submit completed forms to ClientRelations@DeltaDentalOK.org.



Step 6 – FULLY INSURED PLAN OPTIONS AND PLAN SELECTION (select all that apply)

A minimum of two (2) enrolled Eligible Employees is required for participation in Select plans. At least one (1) Eligible Employee must be enrolled in a plan option in order for that option to be available to the group. **For each plan offered, please enter the number of Eligible Employees expected to enroll. Please contact our Sales team at Sales@DeltaDentalOK.org or via phone at 405-607-4709 (OKC Metro) or 866-685-2112 (Toll Free) for questions.**

2023 MONTHLY RATES	Delta Dental PPO – Preventive Plus	Delta Dental PPO	Delta Dental PPO – Plus Premier	Delta Dental PPO – Plus Premier “Elite”
Employee Only:	\$23.00	\$34.00	\$50.00	\$82.00
Employee + Spouse:	\$46.00	\$70.00	\$98.00	\$164.00
Employee + Child(ren):	\$57.00	\$86.00	\$130.00	\$213.00
Employee + Family:	\$77.00	\$116.00	\$193.00	\$303.00

BENEFITS SUMMARY

Delta Dental PPO – Preventive Plus

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	n/a
	Class IV – Orthodontic Services	n/a
Maximum Benefit Payment Per Person Per Calendar Year	Class I and II Services Combined	\$750
Maximum Lifetime Benefit Payment Per Eligible Dependent Child Deductible Per Calendar Year	Class IV Services	n/a
	Class II Services Only	\$50 Per Person

Delta Dental PPO

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	50%
	Class IV – Orthodontic Services	50%
Maximum Benefit Payment Per Person Per Calendar Year	Class I, II and III Services Combined	\$1,500
Maximum Lifetime Benefit Payment Per Eligible Dependent Child Deductible Per Calendar Year	Class IV Services	\$1,500
	Class II and III Services Only	\$50 Per Person

Delta Dental PPO – Plus Premier

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	50%
	Class IV – Orthodontic Services	50%
Maximum Benefit Payment Per Person Per Calendar Year	Class I, II and III Services Combined	\$1,500
Maximum Lifetime Benefit Payment Per Eligible Dependent Child Deductible Per Calendar Year	Class IV Services	\$1,500
	Class II and III Services Only	\$50 Per Person

Delta Dental PPO – Plus Premier “Elite”

Covered Services and Plan Co-payment Percentages	Class I – Diagnostic and Preventive Services	100%
	Class II – Basic Services	80%
	Class III – Major Services	50%
	Class IV – Orthodontic Services	50%
Maximum Benefit Payment Per Person Per Calendar Year	Class I, II and III Services Combined	\$3,000
Maximum Lifetime Benefit Payment Per Eligible Person Deductible Per Calendar Year	Class IV Services	\$2,000
	Class II and III Services Only	\$50 Per Person

Step 7 – THIRD PARTY ADMINISTRATORS

TPAs listed in this section are authorized to conduct the specified business service(s) below on behalf of the employer group. The Employer authorizes DDOK to communicate and transact with the TPA, as needed, to fulfill applicable transactions and/or reporting.

EDI/Eligibility _____

COBRA Administrator _____

FSA Administrator _____

Other _____



Step 8 – PAYMENT OPTIONS (select one): Online Resources Automatic Draft

All designated Billing Contact(s) will be setup with monthly E-Bill notification emails. Billing Contact(s) may log into Online Resources to view invoice(s) and remit payment, as needed. Each user will receive their Online Resources credentials via two (2) emails upon completion of implementation, one containing the User ID and the other the temporary password. To set up automatic draft for the fifth (5th) day of each month*, please complete the information below. **A voided check must be attached to this authorization form.**

Financial Institution		Branch		Branch Telephone	
Branch Address		City	State	Zip	Account Type (select one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings

I (We) _____ hereby authorize Delta Dental of Oklahoma and the financial institution named above to begin deductions of company dental premium from the account I have indicated herein on the fifth (5th) day of each month.* I understand that company eligibility can be placed on hold for a rejected draft.

Signature**: _____ Date: _____

*If the fifth (5th) day of the month is on a weekend or a holiday, Delta Dental of Oklahoma will debit the specified account on the next business day.

**Signature must be that of an authorized signer on the bank account.

Step 9 – PRODUCER/AGENT INFORMATION

Agency	Five Digit Agency Number	Telephone
City	State	Zip
Producer/Agent Name	Email Address	Online Resources ID
Producer/Agent Assistant Name	Email Address	Online Resources ID
Second Servicing Producer/Agent Name	Email Address	Online Resources ID

Step 10 – ACKNOWLEDGEMENT AND SIGNATURES

Delta Dental has not reviewed the employer’s request for plan coverage nor designed the group plan to meet any federal requirements for Discriminatory Employee Benefit Plans. Said plan may not be in compliance with criteria established for Discriminatory Employee Benefit Plans and employer holds Delta Dental Plan of Oklahoma harmless if said plan fails to meet any such requirements.

All information above is true and correct to the best of my knowledge. I have reviewed and accept the benefits and eligibility requirements as stated in this Application for Group Contract. **Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Electronic Delivery/Administration: By executing this Application For Group Contract, I hereby acknowledge that: All Select employer plan documents, enrollee packets, group supplies, billing statements, and notices (renewal, delinquency, and/or termination) shall be provided electronically, and hereby consent to such delivery/administration. I understand that such consent to electronic delivery/administration may be declined initially, or rescinded in the future by providing Delta Dental of Oklahoma with written notice of intent to rescind such consent at least 30 days prior to the rescission effective date. Further, I acknowledge that failure to consent initially to electronic delivery/administration of the Select group dental plan, or future rescission of consent shall result in a \$15.00 monthly paper delivery/administration fee, which shall be included in the monthly billing statements and payable under the same terms and conditions as the monthly premiums.

Employer’s Authorized Signature	Title	Date
Producer/Agent Signature		Date

New Group Kit

All Select employer plan documents, enrollee packets and group supplies will be provided electronically. The new group kit will be emailed to the designated Primary Contact and Producer upon completion of new group implementation and contains the welcome letter, Plan Agreement, Summary Plan Description and electronic identification cards.



Enrollment/Eligibility Update

PLAN TYPE:
(AS ESTABLISHED
BETWEEN EMPLOYER
AND DELTA DENTAL)

- DELTA DENTAL PPO - PREVENTIVE PLUS
- DELTA DENTAL PPO
- DELTA DENTAL PPO - PLUS PREMIER
- DELTA DENTAL PPO - PLUS PREMIER "ELITE"
- DELTA DENTAL PREMIER
- DELTA DENTAL PREMIER - CHOICE
- DELTA DENTAL PPO - CHOICE
- DELTA DENTAL PPO - CHOICE ADVANTAGE
- DELTA DENTAL PPO - POINT OF SERVICE

SEE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS, EXPLANATION OF CODES AND PRIVACY POLICY STATEMENT.

Employer: _____

GROUP#/SUBGROUP# LOCATION CODE

Subscriber Information: (please complete in ink for enrollment/eligibility updates)

SUBSCRIBER NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX	MARITAL STATUS
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> S
SUBSCRIBER SOCIAL SECURITY NUMBER	BIRTH DATE	FULL-TIME HIRE DATE	COVERAGE EFFECTIVE DATE		STATUS	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Dep. <input type="checkbox"/> Other: _____	
ADDRESS						
CITY			STATE	ZIP	CHECK HERE IF THIS IS A NEW ADDRESS <input type="checkbox"/>	

E-MAIL: _____

Enrollment/Eligibility Update Information: EFFECTIVE DATE OF UPDATE/CHANGE/TERMINATION: - -

TYPE OF ENROLLMENT/ELIGIBILITY UPDATE:		REASON FOR CHANGE:	
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> REINSTATEMENT	<input type="checkbox"/> CHANGE IN CURRENT ENROLLMENT STATUS FOR:	<input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> DEPENDENTS
<input type="checkbox"/> COBRA ELECTION	<input type="checkbox"/> TERMINATION OF BENEFITS	<input type="checkbox"/> DIVORCE	<input type="checkbox"/> MARRIAGE
<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> DECLINE	<input type="checkbox"/> NAME CHANGE	<input type="checkbox"/> LEGAL GUARDIANSHIP
<input type="checkbox"/> TERMINATION OF EMPLOYMENT AS OF _____ - _____ - _____		<input type="checkbox"/> ADOPTION	<input type="checkbox"/> OTHER _____

GROUP TRANSFER-GROUP#/SUBGROUP# TO: GROUP#/SUBGROUP#

Dependent Enrollment/Eligibility Update Information: (please complete for spouse and/or dependent children for enrollment/eligibility update)

SPOUSE NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE				
<input type="text"/>	<input type="text"/>				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*			
<input type="text"/>	<input type="text"/>				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*			
<input type="text"/>	<input type="text"/>				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*			
<input type="text"/>	<input type="text"/>				
DEPENDENT CHILD NAME (LAST)		(FIRST)	(M.I.)	SUFFIX	SEX
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> DISABLED*			
<input type="text"/>	<input type="text"/>				

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, provides false information herein and makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

By signing this form, I agree to continue enrollment as provided by the contract between my Employer and Delta Dental of Oklahoma and acknowledge I have read the privacy policy detailed on the back of this form.

Subscriber's Signature: _____ Date: _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or updating/changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed in order to process your enrollment or update your records. All information in this section should apply to you, the primary subscriber. Please print clearly in ink.

Full-Time Hire Date: The date you were hired with your employer.

Coverage Effective Date: The date Delta Dental coverage takes effect for you (and/or your dependents, if enrolled).

Status Definitions (Please select only one status)

Active You are an eligible subscriber.

Retiree You are retired and your employer continues to provide you with dental benefits.

COBRA You are no longer an active subscriber but you have continued coverage under COBRA. Please check with your human resources or personnel department for information regarding COBRA.

Surviving Dep. The surviving spouse or child of a deceased subscriber to whom the employer continues to provide benefits other than under provisions of COBRA.

Enrollment/Eligibility Update Information - This section should only be completed if you are: (1) enrolling yourself or a family member for the first time or (2) if your benefits were terminated and are not being reinstated or (3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your eligible dependents.

Reinstatement: Check for reinstatement coverage for yourself or your eligible dependents.

Termination of Benefits: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Group Transfers: Must be completed when you are transferring from one subgroup to another. (All dependents will transfer)

Dependent Enrollment/Eligibility Update Information - This section should be completed when: (1) enrolling dependents or (2) if you are submitting updates/changes to Delta Dental enrollment. (Please include both first and last names of any individuals for whom you are enrolling or submitting an update or change).

* Disabled: Your permanently disabled dependent child. (Requires submission of medical statement)

Delta Dental of Oklahoma Privacy Policy

All companies part of the Delta Dental of Oklahoma family of companies (referred to in this Privacy Policy as "Delta Dental") believe that personal information collected about our customers, subscribers, potential customers, and proposed subscribers (referred to collectively in this Privacy Policy as "Customers") must be treated with the highest degree of confidentiality. For this reason and in compliance with the Gramm-Leach-Bliley Act of 1999, Delta Dental has developed a Privacy Policy that applies to all employees, officers, directors, agents, brokers, and to any other transaction Delta Dental has which may contain your confidential information. Financial companies are able to choose how they share your personal information, however Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

Information We Collect - We collect and maintain personal, nonpublic information we receive from Customers directly, through applications, enrollment forms, check, credit or debit card payments, insurance claims, and our website. We also collect your personal information from other companies. The types of personal information we collect and share depend on the product or service you have with us. This information can include your name, address, social security number, date of birth, transaction and claim history, medical information, and checking account information.

Utilization Of Information - Delta Dental has, and will continue to utilize non-affiliated third parties to conduct certain functions of our business in order to provide our Customers with services and products. These functions include processing your requests, claims and transactions, maintaining your account(s), providing information about new products, responding to court orders and legal investigations, reporting to credit bureaus, and to comply with Federal and State Laws. The information Delta Dental uses to provide a service cannot be restricted by our Customers. However, Delta Dental is able to limit this information on your behalf under HIPAA.

Federal law gives consumers the right to limit information sharing in relation to affiliates' everyday business purposes, information about your creditworthiness, affiliates using your information to market to you, and non-affiliates using your information to market to you. In addition, state laws and other individual companies may give you additional rights to limit sharing.

Delta Dental does not have any affiliates, nor do we share information with non-affiliates for marketing purposes. When you are no longer our Customer, we will continue to share your information as described in this notice.

Our Security - To protect your personal information from unauthorized access and use, we maintain physical, electronic, and procedural safeguards that comply with Federal Law, including computer safeguards and secured files and buildings. We consider nonpublic personal information to be confidential, and treat it as such. The personnel who have access to this information are trained in proper handling of such information. Employees who violate this strict level of confidentiality are subject to our disciplinary process.

While we do make available certain nonpublic personal information to non-affiliated third parties in order to service Customer accounts, all information is strictly governed by confidentiality and security agreements to protect our Customers. Therefore, our Customer's confidential information is protected.

If the group plan is terminated or you terminate your coverage, Delta Dental will adhere to the information practices as described in this notice.

If you have any questions about our Privacy Policy, please do not hesitate to contact your Delta Dental representative at 800-522-0188 (Toll Free) or 405-607-2100 (OKC Metro).

Under no circumstances will we sell information about our Customers or their account to any unaffiliated company, group, or individual without our Customer's permission.

SPOTLIGHT

Time to Focus on Your Smile

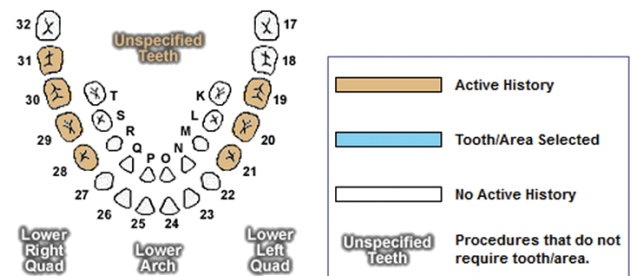
SPOTLIGHT

is **Delta Dental of Oklahoma's** online health services site where subscribers can securely access real-time information regarding their benefits plan.

Maximize your dental benefits:

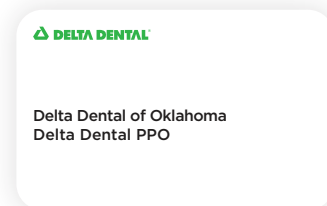
- 🦷 Find a dentist
- 🦷 View benefits
- 🦷 Track claim status
- 🦷 Access Explanation of Benefits
- 🦷 Secure messaging with our Customer Service team

🦷 My Mouth Chart



An individual tooth-by-tooth illustration of recent dental treatment.

🦷 Electronic ID Card



When you bring your own ID Card, you will have the peace of mind that your claims will be paid appropriately.

Visit DeltaDentalOK.org/Spotlight to register and to opt out of receiving paper statements today!



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