Electronic Group Information Form 'How To' Guide

October 2021



Group Information Form



Welcome to Delta Dental

Thank you for taking a few moments to fill out this Group Information Form.

This site is optimized for Microsoft Edge, Google Chrome and Apple Safari.

FireFox, Opera, Vivaldi and other HTML5 browsers may also work, but with decreased performance and slower speeds.

Delta Dental of Michigan, Ohio, Indiana and North Carolina. All rights reserved.

Click Here for the Form

1. Click "Click Here for the From" to open the Group Information Form

Group Information	F	Page Help	Next Page	Form Progress
				O Group Information
*Legal Business Name	Group Name:			Group Contact Information
Enter the Company Name as you would like it to appear on the contract.	Plan:			Benefit Manager Toolkit
				Prior Carrier
* Physical Address	Effective Date: 7/1/2021			Subgroup Information
				Eligibility Age Limits
*City *State (Choose)	Contract Length: 2 Years			Coordination of Benefits
*Zip Code ##### *County	Group Type:			Subscriber Definition
	Risk			Member Waiting Period
Please Note: P.O. Boxes are not acceptable for client location.	Agent Name:			 Termination Language
*Group Tax Identification/EIN #: (XXXXXXXXX)				 HIPAA Group Plan Cert.
				Summary - Form Data
				 Summary - Documents
Save and Finish Later			Next Page	Submission
				(14

2. Complete all fields on the Group Information Page

(14 pages)

Group Information			Page Help 🜗	Next Page	Form Progress
					O Group Information
* Legal Business Name		Group Name:			Group Contact Information
Enter the Company Name as you would like it to appear on the c	ontract.	Plan:			Benefit Manager Toolkit
					Prior Carrier
* Physical Address		Effective Date:			Subgroup Information
*City	* State	Contract Length:			Eligibility Age Limits
	(Choose)	2 Years			Coordination of Benefits
*Zip Code ##### *County		Group Type:			Subscriber Definition
		Risk			Member Waiting Period
Please Note: P.O. Boxes are not acceptable for client location.		Agent Name:			Termination Language
*Group Tax Identification/EIN #: (XXXXXXXXX)					HIPAA Group Plan Cert.
					Summary - Form Data
					Summary - Documents
	Save and Finish Later]		Next Page	 Submission
					(14 pages)

3. Review the non-editable gray fields and contact your Sales Rep if anything is incorrect

Group Information				Page Help 🚯	Next Page	Form Progress
						O Group Information
* Legal Business Name			Group Name:			Group Contact Information
Enter the Company Name as y	/ou would like it to appear on the cor	ntract.	Plan:			Benefit Manager Toolkit
						Prior Carrier
* Physical Address			Effective Date:			Subgroup Information
*City		* State	7/1/2021 Contract Length:			Eligibility Age Limits
		(Choose)	2 Years			Coordination of Benefits
*Zip Code #####	*County		Group Type:			Subscriber Definition
			Risk			 Member Waiting Period
Please Note: P.O. Boxes are n	not acceptable for client location.		Agent Name:			Termination Language
*Group Tax Identification/EIN	I #: (XXXXXXXXXX)					HIPAA Group Plan Cert.
						Summary - Form Data
			_			Summary - Documents
		Save and Finish Later			Next Page	 Submission
						(14 pages)

4. At any point while filling out the form, you can save and finish the form later. Use the same link to access the form again

Group Information			Page Help 🕚	Next Page	Form F	Progress
					0	Group Information
*Legal Business Name		Group Name:				Group Contact Information
Enter the Company Name as you would like it to appear on the con	tract.	Plan:			ļ	Benefit Manager Toolkit
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	(Choose)	2 Years			-	Coordination of Benefits
*Zip Code ##### *County		Group Type:				Subscriber Definition
		Risk			ļ	Member Waiting Period
Please Note: P.O. Boxes are not acceptable for client location.		Agent Name:				Termination Language
* Group Tax Identification/EIN #: (XXXXXXXXXX)					ļ	HIPAA Group Plan Cert.
						Summary - Form Data
						Summary - Documents
	Save and Finish Later			Next Page	•	Submission
						(14 pages)

5. Click "Next Page" to move to the next page. Moving to the next page will also save your information

Next Page

Contact Type Selection

- · Add contacts in the below section by clicking the add contact button
- · Once all contact(s) have been added, please select the Contact Type for your contact
- · Only one contact name is allowed per Contact Type

Contact Role Definitions:

General Contact - This contact will receive a second collection letter if the Billing Contact collection letter goes unanswered.

Renewal Contact - This contact will receive the contract and renewal documents. A Renewal Contact is required for documents, if there is not a renewal contact listed the address on the documents will print blank.

Billing Contact - This contact will receive bills and other materials related to billing. We must have an email address for this contact to send bills via email. This contact also receives an email notification that the invoice is available on Benefit Manager Toolkit (BMT). However, if the client receives their Delta Dental bill in the mail, this is the name and address of the individual receiving that information.

Materials Contact - This contact will receive group materials, such as pamphlets, certificates, summaries, etc. Note: A PO Box cannot be used for the materials contact, and a street address must be entered for this contact type.

Mailing Contact - This contact will receive general, mass mailing information.

Overage Dependent Contact - This contact will receive the email notification that the overage dependent report is ready to be viewed in BMT. This contact type requires an email address.

6. Review the contact role definitions and scroll down to enter contacts

Name	Address	Prefered Ph#/Email	* General
			Choose
	Legend: 🖋 Edit 🍵 Delete 🔰	» Set All Roles	* Renewal
			Choose
			* Billing
			Choose
			* Mailing
			Choose
			* Materials (no P.O. Boxes) 🥝
			Choose
			* Overage Dependent
			Choose
		s been produced and is available to be viewed online?	
1	lo		*

7. Use the green "Add Contact" button to add a contact

							Powered by
Group Information Fo			Edit Contact				Roosevelt
Group Contact Information		Constitution of	ontacts for the Materials Role may no			Progress	
	Contact Name:	Special Note: Co	ntacts for the Materials Kole may ho	t have a P.O. Box.		Group Inf	ormation 1 issues
		* First Name	*Last Name	Suffix			ntact Information
Add con						Benefit M	anager Toolkit
Once all Only one	litle						
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General Cont Renewal Com	6.					Eligibility	Age Limits
there is not a r Billing Contac	Street				Apt/Suite	Coordinat	ion of Benefits
contact to send Toolkit (BMT).	City		State		Zip #####	Subscribe	Definition
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Mailing Conta Overage Depe	¢					Terminatio	on Language
viewed in BMT	Required Method	* Preferred V	Vork Email			HIPAA Gro	oup Plan Cert.
	Work Email						
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Name			Cancel Save			Summary	- Documents
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8. Complete all fields to add the contact

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Group Information Fo		Edit Contact		Roosevelt
Group Contact Information				Progress
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	Salutation * First Name	* Last Name	Suffix	Group Contact Information
 Add cont Once all Only one 	Select 🗘			Benefit Manager Toolkit
				Prior Carrier
General Conta Renewal Conta there is not a re	Address Details: Street		Apt/Suite	Eligibility Age Limits
Billing Contac contact to send Toolkit (BMT). H	123 Tester Street			Subscriber Definition
receiving that in Materials Cont cannot be used	City Middle	State Michigan	Zip #####	Member Waiting Period
Mailing Contac Overage Depen viewed in BMT.	Contact Methods:			Termination Language
	Required Method * Preferred Work Email	Work Email		HIPAA Group Plan Cert.
Contacts	Second Mathad		•	Summary - Form Data
Name		Cancel Save		Summary - Documents
		* Descuel	¥	Submission

9. The address will default to the Group address. Confirm that this is accurate or update to the correct address

Delta Dental's - New Group Process Group Information Fo						Roosevelt
		Edit Contact				
Group Contact Information	Cardia N	lote: Contacts for the Materials Role may n			Progress	
		lote: Contacts for the Materials Role may h	ot have a P.O. Box.		Group Info	ormation 1 issues
	Contact Name: Salutation * First Name	* Last Name	Suffix	4		ntact Information
Add cont	Select					
Once all	Title				Benefit Ma	nager Toolkit
Only one					Prior Carrie	er
General Conta	Address Details:				Eligibility A	Age Limits
Renewal Conta there is not a re	Street			Apt/Suite	Coordinati	on of Benefits
Billing Contact contact to send	123 Tester Street					D () 11
Toolkit (BMT). I receiving that ir	City	State		Zip #####	Subscriber	Definition
Materials Cont cannot be used	Middle	Michigan	÷	12345	Member V	/aiting Period
Mailing Contac Overage Depe viewed in BMT.	Contact Methods:				Terminatio	n Language
viewee in Dirt.	Required Method * Pre Work Email	ferred Work Email			HIPAA Gro	up Plan Cert.
Contacts	Correct Mathed				Summary	- Form Data
					Summany	- Documents
Name		Cancel Save			Summary -	Documents
4			* Donouval		Submissio	n
	egend: 🖋 Edit 🝵 Delete 🛛 🚿 Set All Roles		* Renewal			

10. Enter the contact's email address, and add a secondary contact method if desired

Delta Dental's - New Group Process Group Information Fo				Roosevelt
		Edit Contact		
Group Contact Information	Special Nata C	ontacts for the Materials Role may not have a P.O. Box.		Progress
		Untacts for the materials Role may not have a F.O. DOX.		Group Information
	Contact Name:		^	
	Salutation *First Name	* Last Name Suffix		Group Contact Information
Add cont Once all				Benefit Manager Toolkit
Only one	Title			Prior Carrier
General Conta	Address Details:			Eligibility Age Limits
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Billing Contac contact to send	123 Tester Street			Coordination of Benefits
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Materials Cont cannot be used	Middle	Michigan 🛓	12345	Member Waiting Period
Mailing Contac Overage Depe viewed in BMT.	Contact Methods:			Termination Language
viewed in birr.	Required Method * Preferred V	Work Email		HIPAA Group Plan Cert.
	Work Email			
Contacts	Second Mathad		•	Summary - Form Data
Name		Cancel		Summary - Documents
4				Submission
	Legend: 🖍 Edit 📋 Delete 🔉 Set All Roles	* Renewal		

11. Click "Save" to save the contact. You will be able to make edits to any saved contacts

John Smith 123 Main St. Lansing, MI 00000 johnsmith@company.com Image: A lansing, MI 00000 janebrown@company.com Image: A lansing, MI 0000 janebrown@company.com Image: A lansing, MI 0000 Image: A lansing, MI 0000 Image: A lansing, MI note: Imag	Name	Address	Prefered Ph#/Email		* General		
Jane Brown 123 Main St. Lansing, MI 00000 janebrown@company.com Lagend: Edd: Delete: >>> Set All Roles *Billing Choose *Mailing Choose *Materials not \$0.80001 @ Choose *Materials not \$0.80001 @ Choose *Do you need additional emails notified that a bill has been produced and is available to be viewed online?	John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	✓ 亩 >>>	Choose	÷	
Legend: ✓ Edt Delete >> Set Al Roles Choose	lane Brown	123 Main St. Lansing, MI 00000	ianebrown@company.com		* Renewal		
Legend: Edit Delete <td <="" t<="" td=""><td></td><td></td><td>janebrownie company.com</td><td>· · ·</td><td>Choose</td><td>÷</td></td>	<td></td> <td></td> <td>janebrownie company.com</td> <td>· · ·</td> <td>Choose</td> <td>÷</td>			janebrownie company.com	· · ·	Choose	÷
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* Do you need additional emails notified that a bill has been produced and is available to be viewed online?		Legend: 🖋 Edit 💼 Delete 🚿 Set All Roles			Choose	\$	
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* Overage Dependent Choose Choose * Overage Dependent Choose * Do you need additional emails notified that a bill has been produced and is available to be viewed online?					Choose		
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* Do you need additional emails notified that a bill has been produced and is available to be viewed online?					Choose	÷	
No			ced and is available to be viewed c	nline?			
	No				Ŧ		

12. To edit an existing contact, click the pencil icon. To delete a contact, click the garbage can icon. To set that contact as all roles, click the arrows

ontacts			dd Contact Roles
Name	Address	Prefered Ph#/Email	▲ *General
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	John Smith
Jane Brown	123 Main St. Lansing, MI 00000		* 💼 »»
		janebrown@company.com *	Jane Brown
			* Billing
	Legend: 🖋 Edit 📋 Delete 🔉 Set All Roles		John Smith
			* Mailing
			John Smith
			* Materials (no P.O. Boxes) 🥝
			John Smith
			Choose
			John Smith
			Jane Brown
*Do	you need additional emails notified that a bill has been produ	iced and is available to be viewed onli	le?

Save and Finish Later **Previous Page** Next Page

13. Set a contact to each role by using the arrows or the drop down under each role

Name	Address	Prefered Ph#/Email	-	* General	
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	✓	Choose	÷
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	✓	* Renewal	
	· _ = · · · a · · · · · · · · · · · · · · ·	junes of the company com	· · · ·	Choose	*
				* Billing	
	Legend: 🖋 Edit 💼 Delete 🐝 Set All Roles			Choose	Å.
				* Mailing	
				Choose	* *
				* Materials (no P.O. Boxes))
				Choose	÷
				* Overage Dependent	
				Choose	÷
* Do you No	need additional emails notified that a bill has been produ	iced and is available to be viewed o	online?	\$	

14. Indicate if you need additional emails notified that a bill is available to be viewed online

John Smith	123 Main St. Lansing, MI 00000 🛛 johnsmith@company.com 🛛 💉 💼 ≫	John Smith
Jane Brown	123 Main St. Lansing, MI 00000 janebrown@company.com 💉 💼 »>	* Renewal
Jane Brown		Jane Brown
		* Billing
	Legend: 🖋 Edit 💼 Delete 🔉 Set All Roles	John Smith
		* Mailing
		John Smith
		* Materials (no P.O. Boxes) 🥝
		John Smith
		*Overage Dependent
		John Smith
	* Do you need additional emails notified that a bill has been produced and is available to be viewed online?	
	Yes	÷
	*Additional Billing Emails (please enter with a comma in between each email, i.e. billing@company.com, jane@com	ipany.comj.

Save and Finish Later

15. If yes, add the billing emails that should be notified with a comma between each one

Previous Page

Next Page

John Smith	123 Main St. Lansing, MI 00000 🛛 johnsmith@company.com 🛛 💉 💼 湤	John Smith	÷
Jane Brown	123 Main St. Lansing, MI 00000 janebrown@company.com 💉 💼 »>	* Renewal	
		Jane Brown	\$
		* Billing	
	Legend: S Edit 💼 Delete 🐝 Set All Roles	John Smith	\$
		* Mailing	
		John Smith	\$
		* Materials (no P.O. Boxes) 🥝	
		John Smith	\$
		*Overage Dependent	
		John Smith	\$
	* Do you need additional emails notified that a bill has been produced and is available to be viewed online?		
	Yes	▲	
	*Additional Billing Emails (please enter with a comma in between each email, i.e. billing@company.com, jane@comp	any.com).	
	accounting@company.com, admin@company.com		
	Save and Finish Later	Previous Page	Next Pa

16. Once complete, click "Next Page" to move to the next page

Select one individual within your company to be your Group Administrator and complete the information below. This administrator will be able to create and maintain your accounts as well as create BMT user accounts for additional individuals within your company. Delta Dental will send your administrator an email with registration information and additional instructions.

BMT Administrator must be an employee of the client

Please define who will be the administrator for your accounts:

* Administrator's First Name:	* Administrator's Last Name :
John	Smith
* Administrator's Title	* Email:
Benefits Manager	johnsmith@company.com
* Phone Number: XXX-XXX-XXXX	
123-456-7891	

17. Complete each field to add the BMT administrator

Note: the BMT administrator must be an individual within the company

*I authourize that the assigned Agent/Agency (including General Agents) requires access to the Benefit Manager Toolkit as indicated.

Yes

PLEASE CLICK HERE TO GET A PREVIEW OF THE BENEFIT MANAGER TOOLKIT

What is BMT?

With the Benefit Manager Toolkit $\ensuremath{^{\textcircled{\tiny BMT}}}$ (BMT), benefit managers and third-party administrators can:

- Get real-time benefit and eligibility information 24/7
- Access billing details
- Manage your groups eligibility by entering, editing and terminating members
- Streamline your benefits management process
- Download dentist directories in a printable format



18. If you have an agent, indicate if you want to give your assigned agent/agency access to BMT

*I authourize that the assigned Agent/Agency (including General Agents) requires access to the Benefit Manager Toolkit as indicated.

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PLEASE CLICK HERE TO GET A PREVIEW OF THE BENEFIT MANAGER TOOLKIT

What is BMT?

With the Benefit Manager Toolkit[®] (BMT), benefit managers and third-party administrators can:

- Get real-time benefit and eligibility information 24/7
- Access billing details
- Manage your groups eligibility by entering, editing and terminating members
- Streamline your benefits management process
- Download dentist directories in a printable format



19. Once complete, click "Next Page" to move to the next page

Prior Carrier		Page Help 🚯	Previous Page	Next Page
	* Do you have a prior carrier? Yes * Prior carrier name: 	÷		
	Prior carrier documents			
	No Files Attached.			
	<u>↑</u> C	* Click to Upload a File		
	Save and Finish		Previous Page	Next Page

20. If you have Prior Carrier, type in the prior carrier's name and attach a copy of your invoice or benefit summary

Prior Carrier		Page Help 🕚	Previous Page Next Page
	*Do you have a prior carrier?		
	No	÷	
	Save and Finish		Previous Page Next Page

21. If you do not have a Prior Carrier, select "No" and move on to the next page

Please enter your Plan Information and the associated Subgroup information in the section below.

Information may have been pre-filled by your Sales Representative. You can modify the Plan name and Subgroup names and numbers below.

Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.

See downloadable document for Subgroup structure examples

Plans	
High Plan	🖍 Edit Plan Name
* Subgroup # * Subgroup Name	O Add
0001 Subgroup name	

22. Review the plans and subgroups that have been added for your group

Please enter your Plan Information and the associated Subgroup information in the section below.

Information may have been pre-filled by your Sales Representative. You can modify the Plan name and Subgroup names and numbers below.

Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.

See downloadable document for Subgroup structure examples

Plans	
High Plan	🖍 Edit Plan Name
* Subgroup # * Subgroup Name	🔁 Add
0001 Subgroup name	

23. Edit the plan name with the "Edit Plan Name" button or click into the subgroup name or subgroup number to edit the subgroup name or subgroup number

Please enter your Plan Information and the associated Subgroup information in the section below.

Information may have been pre-filled by your Sales Representative. You can modify the Plan name and Subgroup names and numbers below.

Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.

See downloadable document for Subgroup structure examples

Plans	
High Plan	🖍 Edit Plan Name
* Subgroup # * Subgroup Name	G Add
0001 Subgroup name	

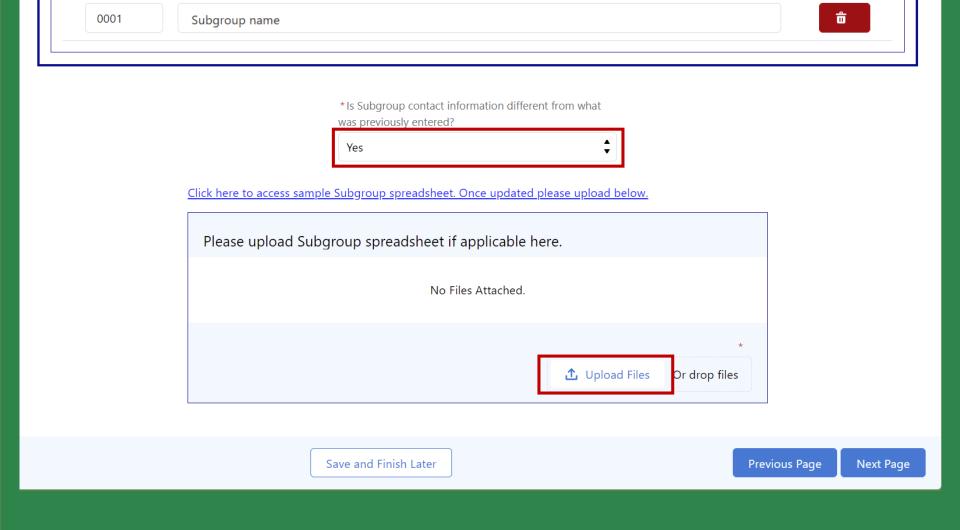
24. If needed, add a subgroup with the green "Add" button or delete a subgroup with the red trash can button

Plans	
High Plan	🖍 Edit Plan Name
* Subgroup # * Subgroup Name	🔁 Add
0001 Subgroup name	
* Is Subgroup contact information different from what	

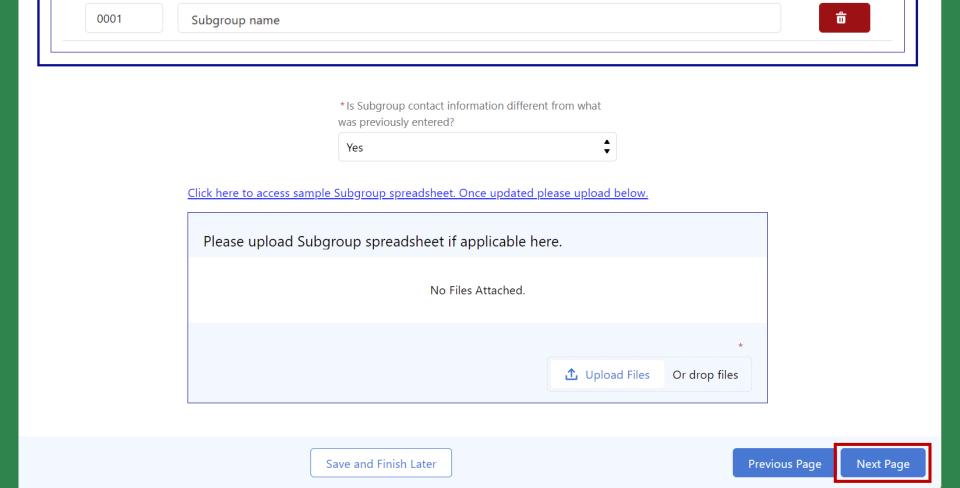
	was previously entered?
1	
	No

Save and Finish Later	Previous Page	Next Page

25. Indicate if the subgroups have different contact information (address, etc) than the group



26. If the subgroups have different contact information, upload a subgroup spreadsheet that includes contact and other information by subgroup



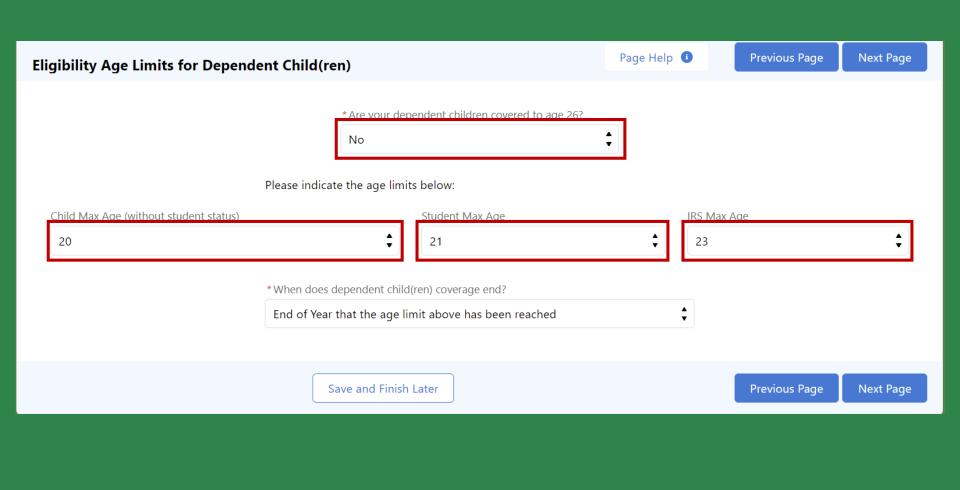
27. Once complete, click "Next Page" to move to the next page



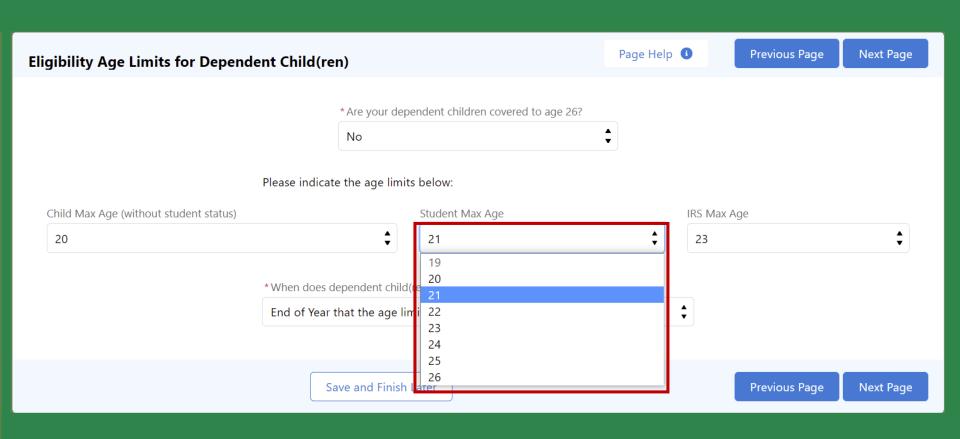
28. Indicate if dependent children are covered to age 26

Eligibility Age Limits for Dependent Child(ren)		Page Help 🚺	Previous Page Next Page
* When do	* Are your dependent children covered to age 26? Yes	\$	
End of Ye	ar that the age limit above has been reached	¢	
	Save and Finish Later		Previous Page Next Page

29. If dependent children are covered to age 26, select when coverage ends



30. If dependent children are not covered to age 26, indicate ages for each dependent



31. The age limits are selected from each drop down. The Child Max Age selected should be lower than the student max age, which should be lower than the IRS max age

Eligibility Age Limits for Dependent Child(ren)		Page Help Previous Page	Next Page	
	* Are your dependent children covered to age 26?			
	No	\$		
Please indicate the age limits below:				
Child Max Age (without student status)	Student Max Age	IRS Max Age		
20	\$ 21	€ 23	\$	
* When de	oes dependent child(ren) coverage end?			
End of ^v	Year that the age limit above has been reached	\$		
	Save and Finish Later	Previous Page	Next Page	

32. Once age limits have been indicated, select when coverage ends

Eligibility Age Limits for Dependent Child(ren)			Page Help	Previous Page	Next Page
	No		•		
Please indicate the age limits below:					
Child Max Age (without student status)		Student Max Age		IRS Max Age	
20	\$	21	▲ ▼	23	\$
*When does dependent child(ren) coverage end? End of Year that the age limit above has been reached (Choose) To Birthdate that the age limit above has been reached					
	End Of Month that the age limit above has been reached End of Year that the age limit above has been reached End of Benefit Period that the age limit above has been reached			Previous Page	Next Page

33. Select one of the coverage end options from the drop down list

Eligibility Age Limits for Dependent Child(ren)		Page Help	D	Previous Page	Next Page	
	* Are vour depe	endent children covered to age 26?				
	No					
	Please indicate the age limits					
Child Max Age (without student status)	Student Max Age		IRS Max Age			
20	÷	21	*	23		ŧ
	* When does dependent child(End of Year that the age lin					
	Save and Finish Later				Previous Page	Next Page

34. Once complete, click "Next Page" to move to the next page

Standard		÷	
	For a definition of payment types, see Po	nge Help	
* Support Interr other:	al COB - Plan will allow spouses with same emp	ployer to cover each	_
Νο		÷	
For a	dditional information on Internal COB, s	see Page Help	-
	Idditional information on Internal COB, s nal COB - Plan will allow spouses with different		-
* Support Extern			
* Support Extern each other: Yes		employers to cover	
* Support Extern each other: Yes	nal COB - Plan will allow spouses with different dditional information on External COB, s	employers to cover	

35. Complete all fields. See the Page Help for a definition of COB terms

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PAGE HELP

Please fill out each field to the best of your ability. You will not be able to move forward until you have completed each required field. Defaults have been selected for the most common answer, but you may change any selection on the defaulted field. Please contact your Sales Rep if you have any questions throughout the process.

Coordination of Benefits (COB) is a procedure for paying health care expenses when people are covered by more than one plan. The goal of COB is to make sure the combined payments of the plan do not exceed the amount of your actual bills.

- This is internal COB "No" definition: Coordination of Benefits If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.
- This is internal COB "Yes" definition: Coordination of Benefits If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your dependent Children may be enrolled on both you and your Spouse's application as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Support External COB: Plan will allow spouses with different employers can cover each other.

Payment Option Types definitions:

Close

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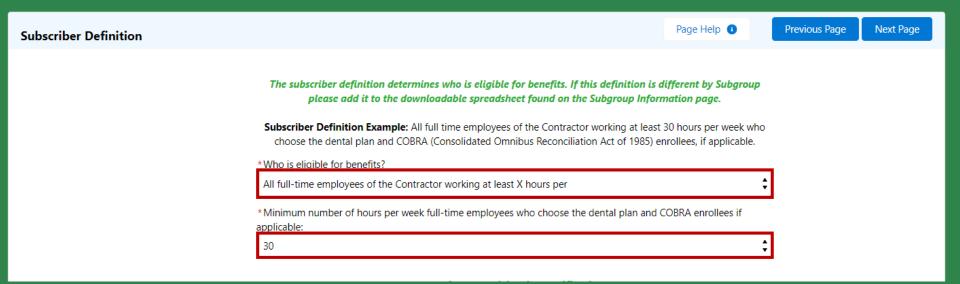
ormat

- For

36. The Page Help section has definitions of COB terms. Click "Close" to return to the form

Standard	
For a definition of payment t	rpes, see Page Help
Support Internal COB - Plan will allow spouses w :her:	th same employer to cover each
No	;
No For additional information on Inte	
	rnal COB, see Page Help
For additional information on Inte Support External COB - Plan will allow spouses w	rnal COB, see Page Help
For additional information on Inte Support External COB - Plan will allow spouses w ach other:	rnal COB, see Page Help
For additional information on Inter Support External COB - Plan will allow spouses w ach other: Yes	rnal COB, see Page Help

37. Once complete, click "Next Page" to move to the next page



38. Indicate who is eligible for benefits and the minimum number of hours per week needed for full-time employees to enroll in dental benefits

	Page Help 🕚	Previous Page	Ne
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choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrol *Who is eligible for benefits?	llees, if applicable.	_	
All full-time employees of the Contractor working at least X hours per	+		
All full-time employees of the Contractor working at least X hours per			
Other			
	The subscriber definition determines who is eligible for benefits. If this definition is diff please add it to the downloadable spreadsheet found on the Subgroup Informat Subscriber Definition Example: All full time employees of the Contractor working at least 30 choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enro *Who is eligible for benefits? All full-time employees of the Contractor working at least X hours per (Choose) All full-time employees of the Contractor working at least X hours per	All full-time employees of the Contractor working at least X hours per (Choose) All full-time employees of the Contractor working at least X hours per	The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page. Subscriber Definition Example: All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable. *Who is eligible for benefits? All full-time employees of the Contractor working at least X hours per (Choose) All full-time employees of the Contractor working at least X hours per

39. If you need to create your own definition, select "Other"

Subscriber Definition		Page Help 👔	Previous Page	Next Page
	The subscriber definition determines who is eligible for benefits. If this definition is a please add it to the downloadable spreadsheet found on the Subgroup Inform			
	Subscriber Definition Example: All full time employees of the Contractor working at least choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) er			
	*Who is eligible for benefits?			
	Other	\$		
	*Other subscriber definition:		_	
	Write definition here			

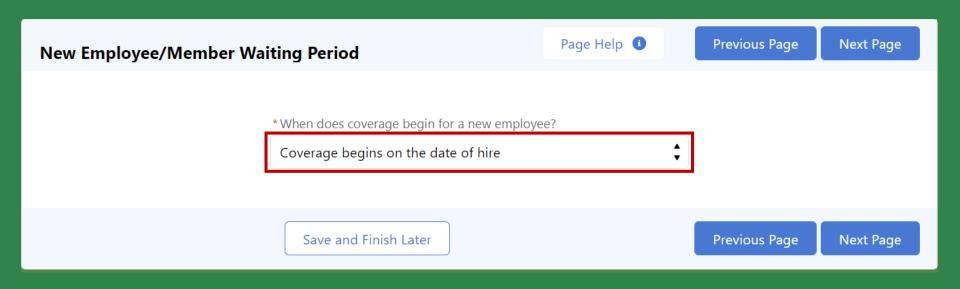
40. Write in the group's desired subscriber definition in the other box

Employer Participation Verification

I verify that all of the individuals eligible for dental coverage have been given the opportunity to enroll in the dental plan offered by Delta Dental. For the undersigned employer, I certify that the number of eligible and enrolled employees for this dental plan of this date:

*Number of Part-Time Employees ELIGIBLE for Dental:	* Number of Part-Time Employees ENROLLED for Dental:
*Number of Retired Employees ELIGIBLE for Dental:	* Number of Retired Employees ENROLLED for Dental:
If a segment has members but they are not e	igible for coverage, enter zero for the number eligible.
If a segment has members but they are not e	igible for coverage, enter zero for the number eligible.

41. Review the Employer Participation Verification section and input the number of employees (full time, part-time, and retired) eligible and enrolled for Dental. Once complete, click "Next Page"



42. Indicate when coverage begins for a new employee

New Emp	loyee/Member	[,] Waiting	Period

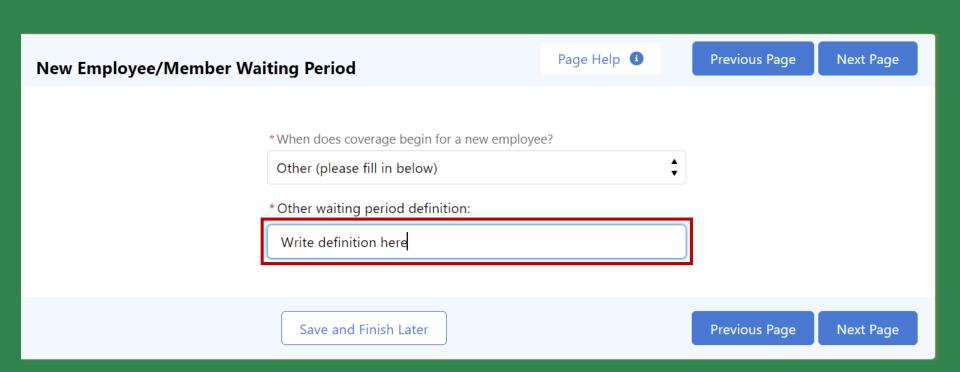
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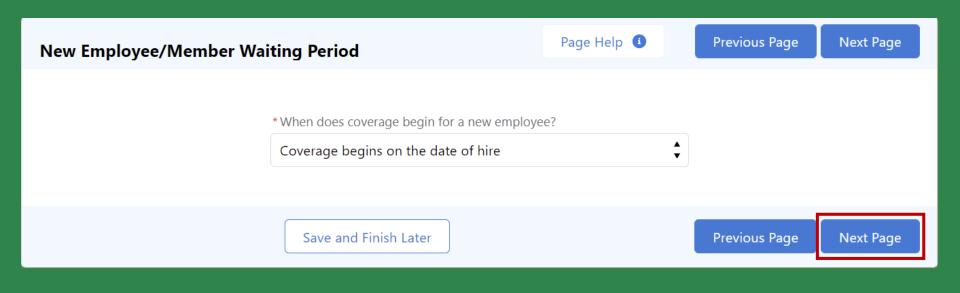
Next Page

* When does coverage begin for a new employee?		
Coverage begins on the date of hire		
(Choose)		
Coverage begins on the date of hire		
Coverage begins X days after hire		
Coverage begins in the first day of the month following X days of employment	s Page	Next Page
Coverage begins on the first day of the month following the date of hire		
Other (please fill in below)		

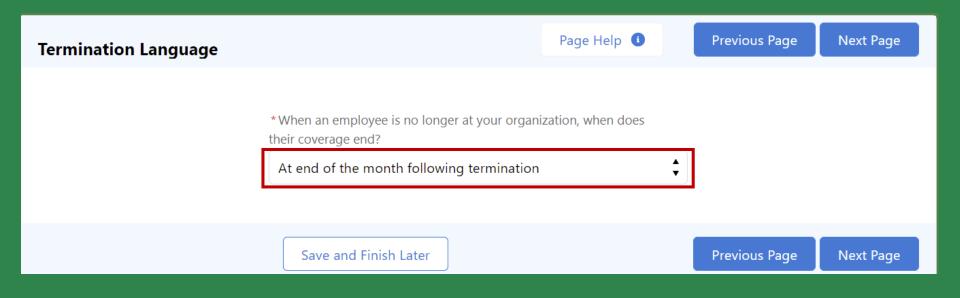
43. Select an option from the drop down or pick Other to add your own definition



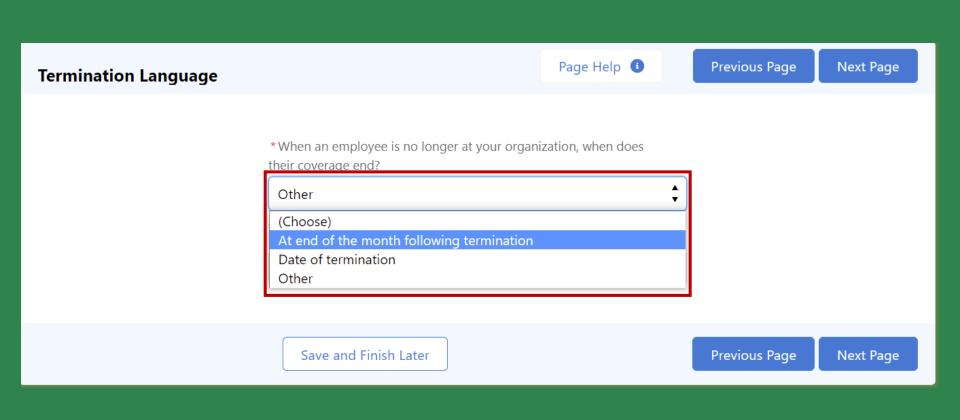
44. If other, write a definition in the other box



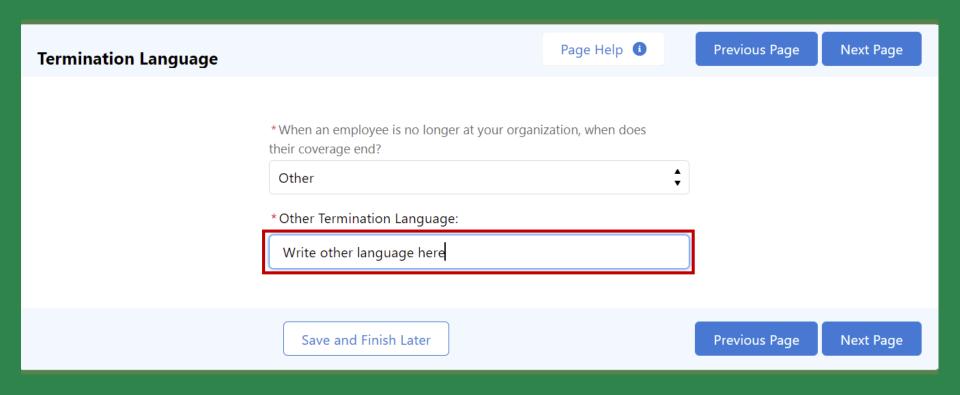
45. Once complete, click "Next Page" to move to the next page



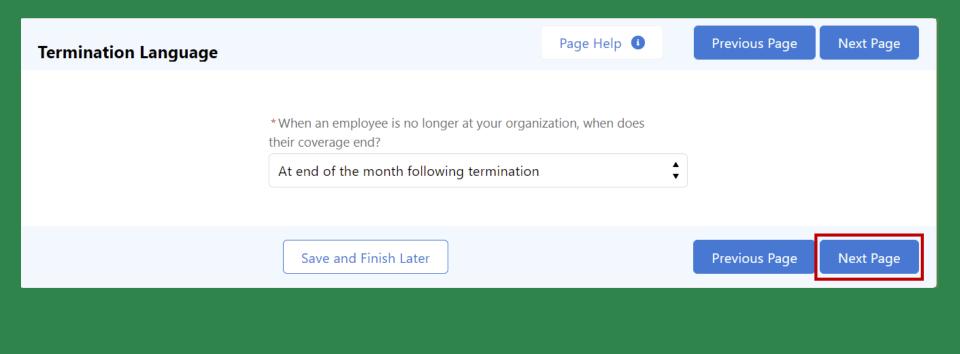
46. Indicate when coverage ends when an employee is no longer with your organization



47. Select an option from the drop down or pick "Other" to add your own definition



48. If other, write in your own termination language



49. Once complete, click "Next Page" to move to the next page

Delta Dental's - New Group Process Group Information Form (eGIF)

HIPAA Group Plan Certific	ation	PDF 🖏	Page Help 🕚	Previous Page	Next Page
The [Client Name Goes Here] G	roup Health Plan ("Plan", through its fiduciary, does hereby certify to the following:				
 That the Plan documents you or required by 45 CFR 164.504(f) Not use or further disclose Ensure that any agents, in c. Not use or disclose PHI for d. Not use or disclose PHI in e. Report to Plan's designee Make PHI available to an i g. Make PHI available for arr Make PHI available for arr Make internal practices, bi the Plan's compliance with j. Ensure the adequate sepa k. If feasible, return or destruction is not 	aration between the Plan and the Plan Sponsor is established as required by HIPAA (45 CFR by all PHI received from Plan that you, as Plan Sponsor, still maintain any form and retain no t feasible, you will limit further uses and disclosures to those purposes that make the return d	gally required to i e plan documents ons that apply to y closures provided s; o the Secretary o e 164.504(f)(2)(iii) copies of such P	or as required by law; you with respect to such info d for; of the U.S. Department of He y; and HI when no longer needed 1	ormation; ealth and Human Servio	ces to determine
-	ies that he or she has the authority to sign on behalf of the Plan.				
Accept	Printed Name of Plan Fiduciary Representative:			/	
	The field above does not qualify as an electron a signature form must be downloaded, signed, and	-	low.		
	Click here to download Signature Form. Once signed please click the attach file butto	on below to com	nplete the HIPAA Group P	lan Certification.	

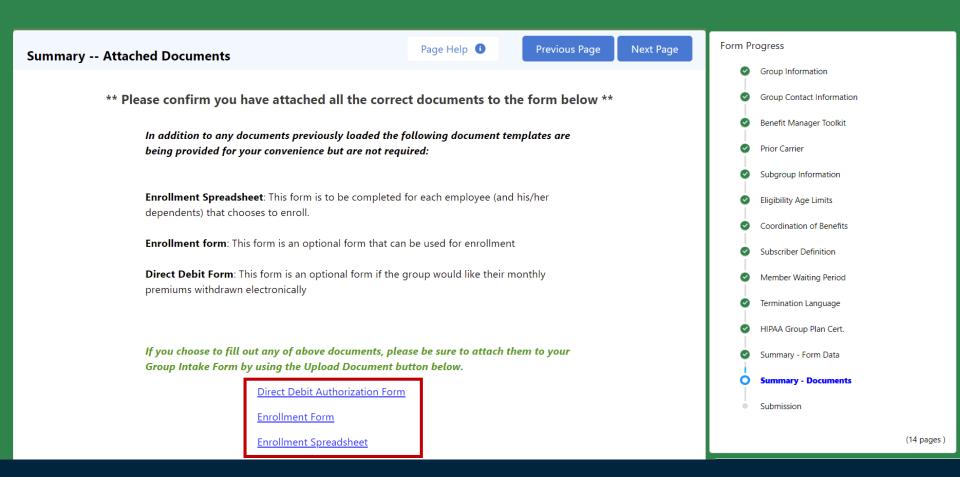
50. Note for a Risk Group you will need to accept or reject HIPAA agreement. If accepted t, you must download, sign, and upload the form.

Summary - Form Data	Page Hel	p 🚺 Previous Page	Next Page	Form Progress
				Group Information
	<i></i>	· · · · · · · · · · · · · · · · · · ·		 Group Contact Information
<u>Please review All Info</u>	ormation for Accuracy prior	<u>to submitting</u>		 Benefit Manager Toolkit
Name and Address				Prior Carrier
Legal Business Name:				Subgroup Information
Group Name				 Eligibility Age Limits
Tax ID:				Coordination of Benefits
123456789				Subscriber Definition
Address:				Member Waiting Period
123 Main St				Variation Language
City:	State:			HIPAA Group Plan Cert.
Lansing	Michigan			O Summary - Form Data
Zip Code: County:				Summary - Documents
00000 Inghan	n			Submission
Effective Date:				(14 pages)
5/27/2021				

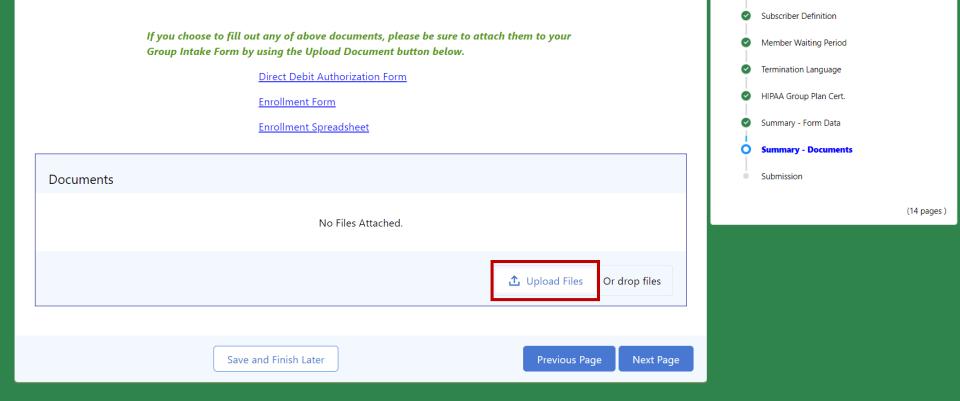
51. Once you have completed all pages, review the information on the Summary page. You can edit some information from this page, or move back to a previous page to make updates

1001 Subgroup name	
an	🖍 Edit Plan Name
* Subgroup # * Subgroup Name	🕀 Add
2001 Subgroup name	a

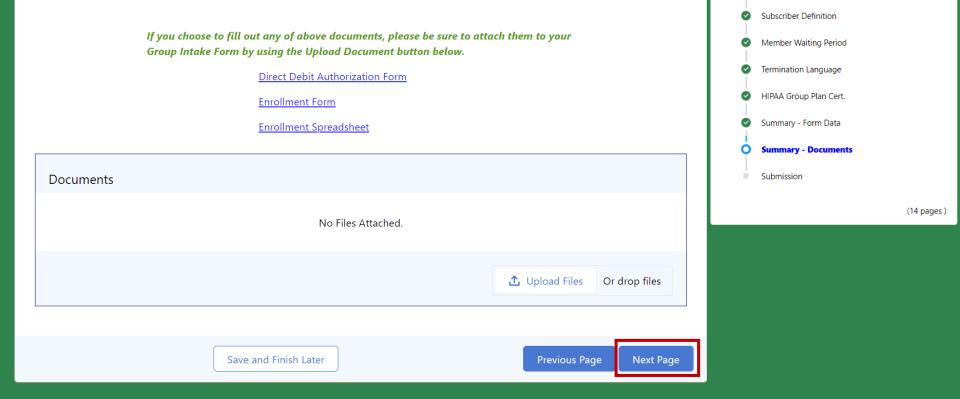
52. Once complete, click "Next Page" to move to the next page



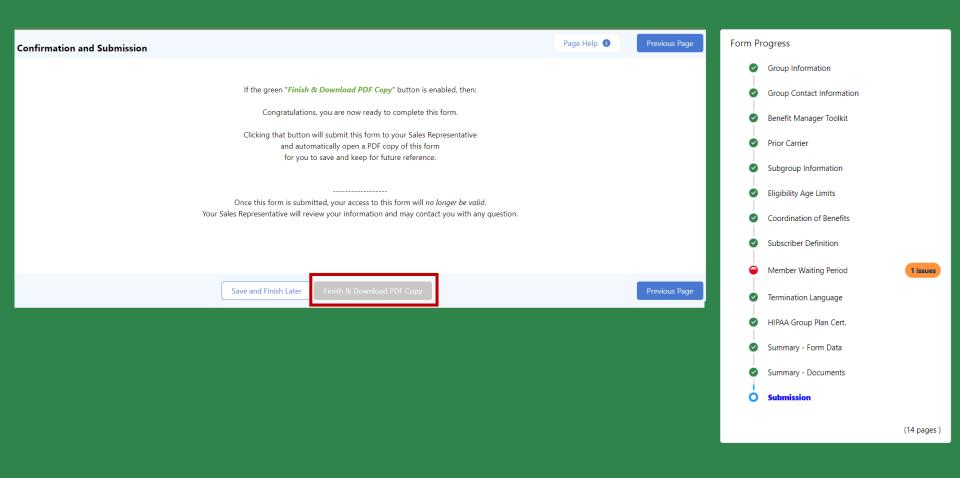
53. After all information has been reviewed, attach any documents that need to be included with your Group Information Form. Optional documents are available to be downloaded from this page



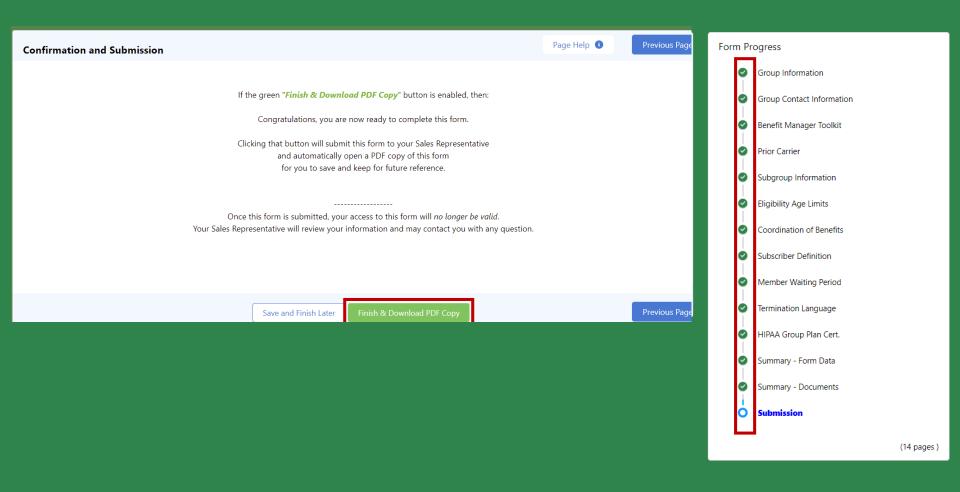
54. Upload documents that need to be included with your Group Information Form



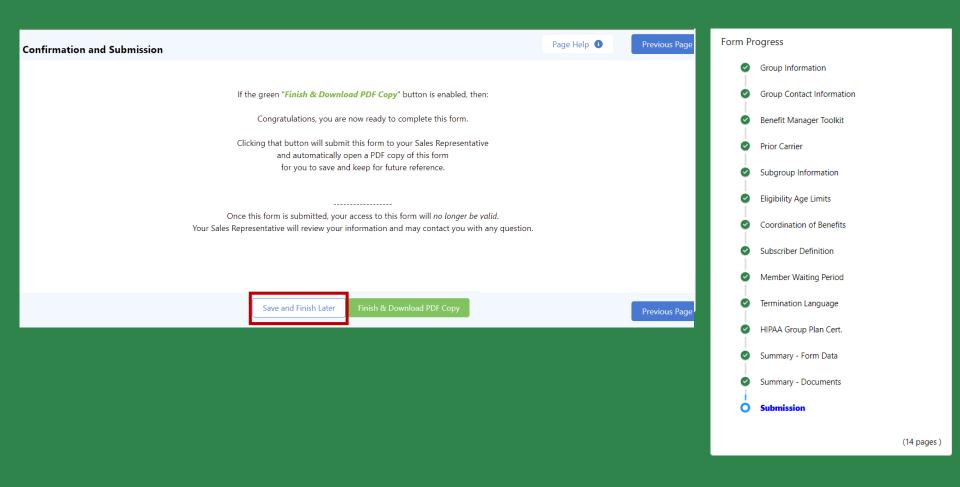
55. Once complete, click "Next Page" to move to the next page



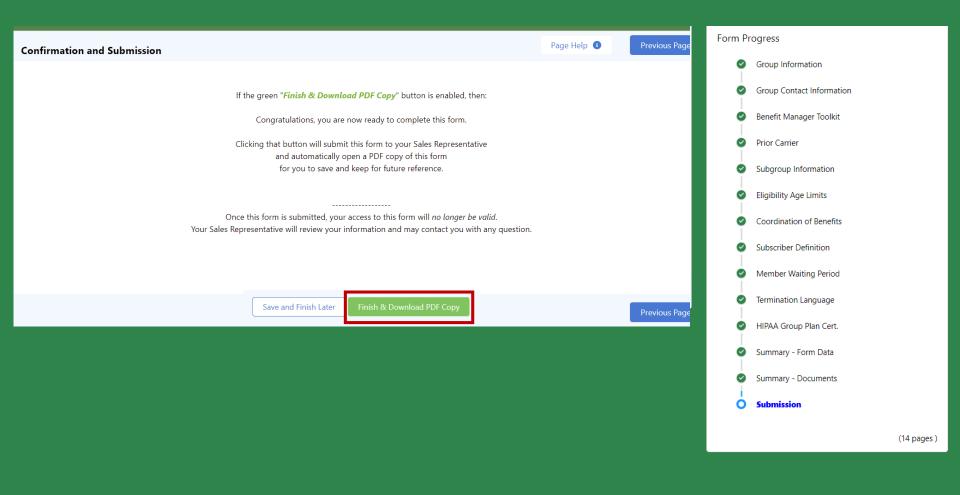
56. If the "Finish & Download PDF Copy" button is gray, go back to the page with an issue to compete it



57. Once all pages have been completed, the "Finish & Download PDF Copy" is green, and you have all green checks on the right-hand menu, you are ready to submit

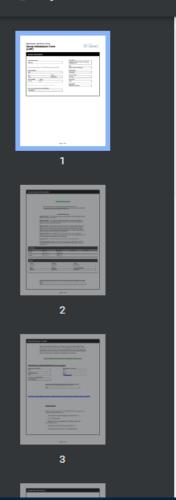


58. If you are not ready to submit, use the "Save and Finish Later" button to save all of your information. You can return to the form at any time using the same link



59. Once you are ready to submit, click "Finish & Download PDF copy" to submit the form

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Delta Dental's - New Group Process Group Information Form (eGIF)



Legal Business Name		Group Name:	
test test			
		Plan:	
Enter the Company Name as you would like it to	o appear on the contract.	Delta Dental of Michigan	
Physical Address		Effective Date:	
test		6/10/2021	
City	State	Contract Length:	
test	Michigan	2 Years	
Zip Code ##### County		Group Type:	
11111 test		Risk	
		Agent Name:	
Please Note: P.O. Boxes are not acceptable for	client location.		
Group Tax Identification/EIN #: (XXXXXXXXX)		
123456789			

60. You have submitted the Group Information Form. You can now download a PDF of the form for your records. Reach out to your Sales Rep is you have any questions.