

SERFF Tracking Number: DDPA-126010870 State: Arkansas  
 Filing Company: Dentegra Insurance Company State Tracking Number: 41553  
 Company Tracking Number: 09-0015  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: AARP-DIC (AARP Enrollment Forms - AR)  
 Project Name/Number: AARP-DIC (AARP Enrolment Forms - AR)/09-0015

## Filing at a Glance

Company: Dentegra Insurance Company

Product Name: AARP-DIC (AARP Enrollment Forms - AR) SERFF Tr Num: DDPA-126010870 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- Closed State Tr Num: 41553

Sub-TOI: H10G.000 Health - Dental Co Tr Num: 09-0015 State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: Chastity Yusta Disposition Date: 02/13/2009

Date Submitted: 02/13/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: AARP-DIC (AARP Enrolment Forms - AR)

Project Number: 09-0015

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/13/2009

Deemer Date:

Submitted By: Chastity Yusta

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 02/13/2009

Created By: Chastity Yusta

Corresponding Filing Tracking Number: 09-0015

Filing Description:

Dentegra Insurance Company (DIC) is submitting the above referenced group dental insurance enrollment forms for approval. These forms replace forms that were previously approved, as shown below. Please note that the yellow highlighted text in the redline version reflects changes from the previously approved version.

Form No.: DN1AR

Description: Enrollment Form

Replaces Form No: DN1AR

SERFF Tracking Number: DDPA-126010870 State: Arkansas  
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Project Name/Number: AARP-DIC (AARP Enrolment Forms - AR)/09-0015  
Previous Form Approval Date: 11/30/2004

The revised form reflects the following updates from the previous approved form:

- „Q Company logo;
- „Q 4 digit zip code extension;
- „Q Added language notifying enrollees of family member enrollment within 31 days of qualifying event as of January 1, 2009;
- „Q Added language that rates are valid for enrollees whose coverage begins on or before 12/1/XX.

Included as supporting documentation are:

- „Q Cover Letter;
- „Q Readability Certification;
- „Q Redlines of Enrollment Forms and
- „Q Original Filing Approval on November 30, 2004.

Thank you for your assistance with our filing process.

## Company and Contact

### Filing Contact Information

Chastity Yusta, Regulatory Analyst cyusta@delta.org  
11155 International Drive 916-861-2768 [Phone]  
Rancho Cordova, CA 95670 916-861-2748 [FAX]

### Filing Company Information

Dentegra Insurance Company CoCode: 73474 State of Domicile: Delaware  
100 First Street Group Code: 2479 Company Type: LAH  
San Francisco, CA 94105 Group Name: Dentegra Group, Inc. State ID Number:  
(866) 714-7730 ext. [Phone] FEIN Number: 75-1233841

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: Delaware form filing fee is \$50, which is greater than Arkansas Filing Fees. Per general

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instructions, if domicile fee higher, companies should pay the higher rate.

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Dentegra Insurance Company	\$50.00	02/13/2009	25715832

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/13/2009	02/13/2009

*SERFF Tracking Number:*      *DDPA-126010870*                      *State:*                      *Arkansas*  
*Filing Company:*              *Dentegra Insurance Company*                      *State Tracking Number:*      *41553*  
*Company Tracking Number:*      *09-0015*  
*TOI:*                      *H10G Group Health - Dental*                      *Sub-TOI:*                      *H10G.000 Health - Dental*  
*Product Name:*              *AARP-DIC (AARP Enrollment Forms - AR)*  
*Project Name/Number:*      *AARP-DIC (AARP Enrolment Forms - AR)/09-0015*

## **Disposition**

Disposition Date: 02/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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*Filing Company:*              *Dentegra Insurance Company*                      *State Tracking Number:*      *41553*  
*Company Tracking Number:*      *09-0015*  
*TOI:*                      *H10G Group Health - Dental*                      *Sub-TOI:*                      *H10G.000 Health - Dental*  
*Product Name:*              *AARP-DIC (AARP Enrollment Forms - AR)*  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	DN1AR Redlines	Approved-Closed	Yes
<b>Supporting Document</b>	Original Apvl of Filing 11/30/04	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Enrollment Form	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: DN1AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/13/2009	DN1AR	Application/Enrollment Form	Enrollment Form	Initial		55.000	DN1AR.pdf



administered by



Delta Dental Insurance Company

# Enrollment Application

Mail completed form with payment to:  
AARP Dental Insurance Plan  
c/o Delta Dental Insurance Company  
P.O. Box 2059  
Mechanicsburg, PA 17055-0759

**Delta Dental Use Only**

Check/Charge	Date Processed	Amount	Eff. Date	Sub Group	Processed By
Auth. Code					
Customer Number					

AARP Member Number	Applicant	
	Date of Birth MM/DD/YYYY	Sex M/F

## A. Applicant

This section must be completed. You must be an AARP member to enroll. Please print clearly.

Last Name	First Name	MI
Street Address		
City	State	ZIP Code
(      )		
Daytime Telephone	E-mail Address	

## B. Family Members

Complete this section if you are enrolling your spouse, domestic partner and/or your family member(s). You must enroll eligible family members at the time of enrollment or within 31 days of a qualifying event.

	First Name	Last Name	Sex M/F	Birthdate MM/DD/YYYY	Disabled? Yes/No
Spouse, Domestic Partner:					
Child:					

# C.

## Dental Insurance Rates

Please check your preferred enrollment option, billing option, plan option and payment method below. You must pay your initial enrollment payment by check, money order or credit card.

### Enrollment Option

- Member Only
- Member + One
- Family (three or more)

### Plan Option

- Plan A
- Plan B

### Payment Method

- Check/money order (Please make payable to Dentegra Insurance Company)

Visa®/MasterCard # \_\_\_\_\_ Exp. Date \_\_\_\_\_ **Card Code** \_\_\_\_\_  
(Last three digits on signature strip on reverse of card.)

American Express # \_\_\_\_\_ Exp. Date \_\_\_\_\_ **Card Code** \_\_\_\_\_  
(Four-digit number on front of card, right-hand side.)

Amount Paid \$ \_\_\_\_\_

\_\_\_\_\_  
 Name as it appears on credit card

\_\_\_\_\_  
 Signature (for credit card payment only) Date

Enclose initial payment based on the selected payment option and coverage in the chart below.

**Note:** If you select EFT monthly, enclose two times the monthly rate and a voided check to begin enrollment.

Payment Frequency	Plan A			Plan B		
	Single	Two Person	Family	Single	Two Person	Family
EFT Monthly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Quarterly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Semi-Annually	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Annually	[\$XX.XX]*	[\$XX.XX]*	[\$XX.XX]*	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]

\*Annual payment option includes a dental accident benefit.

**The rates are valid for enrollees whose coverage begins on or before 12/1/XX.**

For members who enroll after this date, please call toll-free 1-866-XXX-XXXX for current information.

# D.

## Authorization

I have read the information contained in this application and choose to enroll. I understand the benefits and restrictions of the AARP Dental Insurance Plan as stated to me and/or explained in the material provided with the application. I understand that my enrollment is subject to receipt of payment and verification of funds. Eligibility will begin on the first day of the month following receipt of the enrollment form. I understand that the Electronic Funds Transfer (EFT) for the monthly payment option will be automatically deducted from my bank account. I understand that, if I choose to discontinue my enrollment, I will not be eligible to re-enroll within a 12-month period following termination. I hereby certify that the information contained in this application is true and complete.

X \_\_\_\_\_  
 Applicant Signature Date

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

Underwritten by Dentegra Insurance Company and administered by Delta Dental Insurance Company. Dentegra Insurance Company pays a fee to AARP and its affiliate for use of the AARP trademark and other services. Amounts paid are used for the general purposes of AARP and its members.

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	02/13/2009
<b>Comments:</b> Please see attached readability certification.		
<b>Attachment:</b> AR Readability Certification 20090213.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	02/13/2009
<b>Bypass Reason:</b> Submitting Enrollment Form for approval only. The previous approval of the form is include as supporting documentation in this filing. The date of approval is November 30, 2004.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> DN1AR Redlines	Approved-Closed	02/13/2009
<b>Comments:</b> Please see attached redlines for DN1AR.		
<b>Attachment:</b> DN1AR_markup.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Original Apvl of Filing 11/30/04	Approved-Closed	02/13/2009
<b>Comments:</b> Please see original filing approval dated November 30, 2004 (attached).		
<b>Attachment:</b> Supporting Documentation AR ENRL FRMS FILING APVL 20041130.pdf		

	<b>Item Status:</b>	<b>Status</b>
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*SERFF Tracking Number:*      *DDPA-126010870*                      *State:*                      *Arkansas*  
*Filing Company:*              *Dentegra Insurance Company*                      *State Tracking Number:*      *41553*  
*Company Tracking Number:*      *09-0015*  
*TOI:*                      *H10G Group Health - Dental*                      *Sub-TOI:*                      *H10G.000 Health - Dental*  
*Product Name:*              *AARP-DIC (AARP Enrollment Forms - AR)*  
*Project Name/Number:*      *AARP-DIC (AARP Enrolment Forms - AR)/09-0015*

**Satisfied - Item:**      *Cover Letter*    *Approved-Closed*    **Date:**      *02/13/2009*

**Comments:**  
Please see attached cover letter.

**Attachment:**  
AR Cvr Ltr 20090213.pdf



## Readability Certification

ACA 23-80-206(e)

As an authorized representative of the company, we have reviewed the enclosed policy form and certify that, to the best of our knowledge and belief, each form submitted meets your state's minimum statutory requirements relating to the readability of said forms.

Katherine L. Watts

Name

A handwritten signature in blue ink that reads "Katherine L. Watts". The signature is written in a cursive style and is positioned above a horizontal line.

Signature

Vice President, Legal & Regulatory and  
Assistant Secretary

Title

2/11/2009

Date



# Dental Insurance Plan

Dentegra Insurance Company

administered by



← Updated logo.

Delta Dental Insurance Company

## Enrollment Application

Mail completed form with payment to:  
AARP Dental Insurance Plan  
c/o Delta Dental Insurance Company  
P.O. Box 2059  
Mechanicsburg, PA 17055-2059 ← -0759

### Delta Dental Use Only

Check/Charge	Date Processed	Amount	Eff. Date	Sub Group	Processed By
Auth. Code					
Customer Number					

AARP Member Number

Applicant

Date of Birth MM/DD/YYYY

Sex M/F

### A. Applicant

This section must be completed. You must be an AARP member to enroll. Please print clearly.

Last Name

First Name

MI

Street Address

City

State

ZIP Code

( )

Daytime Telephone

E-mail Address

Changed from 'You may enroll any or all eligible family members' to:

### B. Family Members

Complete this section if you are enrolling your spouse, domestic partner and/or your family member(s). You must enroll eligible family members at the time of enrollment or within 31 days of a qualifying event.

	First Name	Last Name	Sex M/F	Birthdate MM/DD/YYYY	Disabled? Yes/No
Spouse, Domestic Partner:					
Child:					

Updated rev date from 1/05 to: 1/09.

# C.

## Dental Insurance Rates

Please check your preferred enrollment option, billing option, plan option and payment method below. You must pay your initial enrollment payment by check, money order or credit card.

### Enrollment Option

- Member Only
- Member + One
- Family (three or more)

### Plan Option

- Plan A
- Plan B

### Payment Method

- Check/money order (Please make payable to Dentegra Insurance Company)

- Visa®/MasterCard # \_\_\_\_\_ Exp. Date \_\_\_\_\_ **Card Code** \_\_\_\_\_  
(Last three digits on signature strip on reverse of card.)
- American Express # \_\_\_\_\_ Exp. Date \_\_\_\_\_ **Card Code** \_\_\_\_\_  
(Four-digit number on front of card, right-hand side.)

Amount Paid \$ \_\_\_\_\_

\_\_\_\_\_  
Name as it appears on credit card

\_\_\_\_\_  
Signature (for credit card payment only) Date

Enclose initial payment based on the selected payment option and coverage in the chart below.

**Note:** If you select EFT monthly, enclose two times the monthly rate and a voided check to begin enrollment.

Payment Frequency	Plan A			Plan B		
	Single	Two Person	Family	Single	Two Person	Family
EFT Monthly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Quarterly	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Semi-Annually	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]
Annually	[\$XX.XX]*	[\$XX.XX]*	[\$XX.XX]*	[\$XX.XX]	[\$XX.XX]	[\$XX.XX]

Changed from 'The rates are valid for members who enroll on or before 12/1/xx' to:

\*Annual payment option includes a dental accident benefit.

**The rates are valid for enrollees whose coverage begins on or before 12/1/XX.**

For members who enroll after this date, please call toll-free 1-866-XXX-XXXX for current information.

# D.

## Authorization

I have read the information contained in this application and choose to enroll. I understand the benefits and restrictions of the AARP Dental Insurance Plan as stated to me and/or explained in the material provided with the application. I understand that my enrollment is subject to receipt of payment and verification of funds. Eligibility will begin on the first day of the month following receipt of the enrollment form. I understand that the Electronic Funds Transfer (EFT) for the monthly payment option will be automatically deducted from my bank account. I understand that, if I choose to discontinue my enrollment, I will not be eligible to re-enroll within a 12-month period following termination. I hereby certify that the information contained in this application is true and complete.

X \_\_\_\_\_  
Applicant Signature Date

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

Underwritten by Dentegra Insurance Company and administered by Delta Dental Insurance Company. Dentegra Insurance Company pays affiliate for use of the AARP trademark and other services. Amounts paid are used for the general purposes of AARP and its members.

Updated rev date from 1/06 to: 1/09.



WESTMONT  
ASSOCIATES, INC.

November 17, 2004

Ms. Rosalind Minor  
Life & Health Division  
Arkansas Department of Insurance  
1200 W. 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

RECEIVED

NOV 19 2004

LIFE AND HEALTH  
ARKANSAS INSURANCE DEPARTMENT

Via UPS Next Day Delivery

**RE: Dentegra Insurance Company**  
**NAIC Group Code: 2479 - NAIC Company Code: 73474**  
**Group Dental Form Filing**  
**DN1AR: Enrollment Form**

**Proposed Effective Date: January 1, 2005**

APPROVED  
NOV 30 2004  
LIFE AND HEALTH  
ARKANSAS INSURANCE DEPARTMENT

Dear Ms. Minor:

On behalf of Dentegra Insurance Company ("Dentegra") we are submitting the referenced Group Dental Insurance Enrollment form for approval pursuant to AR ST § 23-79-109. An authorization letter permitting Westmont Associates to submit this filing on behalf of Dentegra is also enclosed.

The enclosed enrollment form (DN1AR) is identical to enrollment form DN1AR (Rev. 1/04) previously approved on June 21, 2004 with the exception that the new form is being submitted in a variable format so that the rates listed on the forms can be updated as rate changes are implemented without the need to file new forms.

Also enclosed are: Flesch Score Certification and retaliatory (Delaware) filing fee of \$50.00.

Your attention to this submission is appreciated, and we look forward to your department's approval. If you should have any questions, please contact our office.

Respectfully Submitted,

Charles A. Markus  
(chuck@westmontlaw.com)

Enclosures

- Authorization Letter
- Flesch Score Certification
- Enrollment Form
- Filing Fee



DENTEGRA<sup>SM</sup>

INSURANCE COMPANY

May 4, 2004

TO: Department of Insurance  
Life & Health Forms Review Division

RE: Dentegra Insurance Company  
NAIC # 73474; NAIC Group # 2479  
FEIN # 75-1233841  
Readability Certification

To Whom It May Concern:

The company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted meets your state's minimum statutory requirements relating to the readability of said forms.

  
\_\_\_\_\_  
Signature

Charles Lamont, Associate General Counsel  
Authorized Representative, Title







February 13, 2009

VIA SERFF

Life & Health Division  
Arkansas Department of Insurance  
1200 W. 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

**Re: Submittal of Enrollment Forms for (AARP) Dentegra Insurance Company (DIC):**

**Enrollment Form: DN1AR-Enrollment Form**

**NAIC #: 73474**

**SERFF Tracking No.: DDPA-126010870**

**Company Tracking No.: 09-0015**

Dear Sir or Madam:

Dentegra Insurance Company (DIC) is submitting the above referenced group dental insurance enrollment form for approval. This form replaces the form that was previously approved, as shown below. Please note that the yellow highlighted text in the redline version reflects changes from the previously approved version.

<b>Form No.</b>	<b>Description</b>	<b>Replaces Form No.</b>	<b>Previous Form Approval Date</b>
DN1AR	<i>Enrollment Form</i>	DN1AR	11/30/2004

The revised form reflects the following updates from the previous approved form:

- Company logo;
- 4 digit zip code extension;
- Added language notifying enrollees of family member enrollment within 31 days of qualifying event as of January 1, 2009;
- Added language that rates are valid for enrollees whose coverage begins on or before 12/1/XX.

Included as supporting documentation are:

- Cover Letter;
- Readability Certification;
- Redlines of Enrollment Forms and
- Original Filing Approval on November 30, 2004.



Arkansas Department of Insurance  
February 13, 2009  
Page 2

Thank you for your assistance with our filing process. Should you have any questions, please contact me at (916) 861-2768 or at [cyusta@delta.org](mailto:cyusta@delta.org).

Respectfully submitted,



Chastity M. Yusta  
Regulatory Analyst

Enclosures:

- Enrollment Form DN1AR
- Readability Certification
- Redlines of Enrollment Forms (Supporting Documentation)
- Original Filing Approval on November 30, 2004 (Supporting Documentation)