

SERFF Tracking Number: DDAR-127382574 State: Arkansas
Filing Company: Delta Dental of Arkansas State Tracking Number: 49615
Company Tracking Number: DV-ENR-11-B
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: DV-ENR-11-B
Project Name/Number: /

Filing at a Glance

Company: Delta Dental of Arkansas

Product Name: DV-ENR-11-B

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: DDAR-127382574 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49615

Co Tr Num: DV-ENR-11-B

State Status: Approved-Closed

Author: Sara Farris

Reviewer(s): Rosalind Minor

Date Submitted: 08/23/2011

Disposition Date: 08/26/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association

Filing Status Changed: 08/26/2011

State Status Changed: 08/26/2011

Created By: Sara Farris

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

This is an enrollment form for dental and vision; we recently filed this form but left off the fax number where the form is to be faxed. This form adds the fax number back in.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Sara Farris

Company and Contact

Filing Contact Information

Sara Farris,

sfarris@ddpar.com

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1513 Country Club 501-992-1662 [Phone]
 Sherwood, AR 72120 501-992-1663 [FAX]

Filing Company Information

Delta Dental of Arkansas CoCode: 47155 State of Domicile: Arkansas
 1513 Country Club Rd. Group Code: Company Type:
 Sherwood, AR 72120 Group Name: State ID Number:
 (501) 992-1662 ext. [Phone] FEIN Number: 71-0561140

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Delta Dental of Arkansas	\$50.00	08/23/2011	50874478

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/26/2011	08/26/2011

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Disposition

Disposition Date: 08/26/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	DV-ENR-11-B	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/26/2011	DV-ENR-11-B	Application/ DV-ENR-11-B Enrollment Form	Initial		0.000	DV-ENR-11B.pdf

Delta Dental of Arkansas
 P.O. Box 15965
 North Little Rock, AR 72231
 E-mail: eligibility@ddpar.com
 Fax (501) 992-1890

- New Enrollment Status Change Address Change Termination
 Dental Only Vision Only Dental/Vision Cobra

Effective Date:

Month	Day	Year

 Group Number: _____
 Group Name: _____

Social Security Number:

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 Subscriber's Identifier (if applicable): _____

LAST NAME: _____ FIRST: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth: Marital Status Sex Date of Hire
 / / Single Male
 MM DD YY Married Female MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code." Enter P for pregnant, D for diabetes, and H for Heart Disease)
 Pregnancy - Expected due date _____
 Diabetes - Date of onset _____
 Heart Disease - Date of onset _____

1. COVERAGE CHANGES * Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one) Dental <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family Vision <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Family	<input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> Remove Dependent(s) listed below <input type="checkbox"/> Name Change <input type="checkbox"/> Late Entrance (employee) Reason(s) for Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth or adoption of child <input type="checkbox"/> Full Time Student <input type="checkbox"/> Handicapped <input type="checkbox"/> Other _____ <input type="checkbox"/> COBRA effective date _____	<input type="checkbox"/> Change Coverage <input type="checkbox"/> Address Change only <input type="checkbox"/> Qualifying event <input type="checkbox"/> Late Entrance (dependent) Date of event _____ <input type="checkbox"/> Loss of spouse's coverage <input type="checkbox"/> No longer dependent child <input type="checkbox"/> Death of dependent <input type="checkbox"/> No longer Full Time Student
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2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. 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.

- I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time.**
 I authorize payroll deductions.

Signature: _____ Date: _____

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Supporting Document Schedules

		Item Status:	Status
			Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	08/26/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Application	Approved-Closed	08/26/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/26/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	08/26/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/26/2011
Bypass Reason:	N/A		
Comments:			