

State: Arkansas **Filing Company:** Delta Dental of Arkansas
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: DAR-ENR-12A
Project Name/Number: /

Filing at a Glance

Company: Delta Dental of Arkansas
Product Name: DAR-ENR-12A
State: Arkansas
TOI: H10G Group Health - Dental
Sub-TOI: H10G.000 Health - Dental
Filing Type: Form
Date Submitted: 10/16/2012
SERFF Tr Num: DDAR-128729956
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation
Date Requested:
Author(s): Sara Farris
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 10/16/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Delta Dental of Arkansas
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
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General Information

Project Name: Status of Filing in Domicile:
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments:
 Explanation for Combination/Other: Market Type:
 Submission Type: Overall Rate Impact:
 Filing Status Changed: 10/16/2012
 State Status Changed: 10/16/2012 Deemer Date:
 Created By: Sara Farris Submitted By: Sara Farris
 Corresponding Filing Tracking Number:

Filing Description:

This is a revised enrollment form for the State of Arkansas group dental business. We added a fax number and a statement regarding representations/warranties.

Company and Contact

Filing Contact Information

Sara Farris, sfarris@ddpar.com
 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: \$0.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
Delta Dental of Arkansas	\$50.00	10/16/2012	63928231

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/16/2012	10/16/2012

SERFF Tracking #:

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Disposition

Disposition Date: 10/16/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	DAR-ENR-12A	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/16/2012		AEF	DAR-ENR-12A	Initial:	0.000	DAR-ENR-12A.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

ARBenefits Dental



Return form to:
 H&H Employee Benefits Specialists
 1512 Macon Drive, Suite 1A| Little Rock, AR 72211| Fax: (501) 663-1445
 Questions? Call (501) 224-5234 or (888) 224-5233

STATE AGENCY NAME: _____	For internal use only: Delta Dental Group Number: _____ Effective Date: _____ (MM) _____ (DD) _____ (YY)
LAST NAME: _____ FIRST: _____ MI: _____	
SSN: _____ [PERSONNEL NUMBER: _____]	
STREET ADDRESS: _____ CITY: _____	
STATE: _____ ZIP: _____ EMAIL: _____	
PHONE: () _____	Will this replace existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, submit a certificate of credible coverage with effective dates.
DATE OF HIRE: _____(MM)_____(DD)_____(YY)	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH: _____(MM)_____(DD)_____(YY)	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

1. COVERAGE CHANGES

*Please check the box(es) next to the reason for your change

Type of coverage selected & plan option (choose one)

Base Dental

- Employee [\$19.62-V]
 Employee/Spouse [\$39.10-V]
 Employee/Child(ren) [\$38.20-V]
 Employee/Family [\$63.30-V]

Premium Dental

- Employee [\$28.12-V]
 Employee/Spouse [\$56.06-V]
 Employee/Child(ren) [\$54.74-V]
 Employee/Family [\$90.72-V]

Monthly Rates effective [DATE – DATE]

Open enrollment

New Hire

Agency Change

Termination

Status Change

Address Change

Reason(s) for Status Change:

- Marriage*
 Divorce*
 Birth or adoption of child*
 Loss of spouse's coverage*
 No longer dependent child*
 Death of dependent*
 Name Change
 Other

*Date of event above: _____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Add	Remove	Last Name	First Name	MI	Spouse or Dependent	Gender 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"/>						

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 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. Statements made in this application are representations not warranties.

I authorize payroll deductions.

Signature: _____

Date: _____

DAR-ENR-12A

Note: For new hires, the effective date will be first of the month following the signature date provided on this form.

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	10/16/2012
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/16/2012
Bypass Reason:	n/a		
Comments:			