

State: Arkansas **Filing Company:** Delta Dental of Arkansas
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: DDARTA-2013
Project Name/Number: /

Filing at a Glance

Company: Delta Dental of Arkansas
Product Name: DDARTA-2013
State: Arkansas
TOI: H10I Individual Health - Dental
Sub-TOI: H10I.000 Health - Dental
Filing Type: Form
Date Submitted: 12/17/2012
SERFF Tr Num: DDAR-128815150
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: 12/17/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Delta Dental of Arkansas
TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental
Product Name: DDARTA-2013
Project Name/Number: /

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: 12/17/2012
 State Status Changed: 12/17/2012 Deemer Date:
 Created By: Sara Farris Submitted By: Sara Farris
 Corresponding Filing Tracking Number:

Filing Description:

This is the new application for individual dental and vision for the Arkansas Retired Teachers Association.

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 | 12/17/2012 | 65810366 |

SERFF Tracking #:

DDAR-128815150

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Delta Dental of Arkansas

TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

DDARTA-2013

Project Name/Number:

/

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 12/17/2012 | 12/17/2012 |

SERFF Tracking #:

DDAR-128815150

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Delta Dental of Arkansas

TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

DDARTA-2013

Project Name/Number:

/

Disposition

Disposition Date: 12/17/2012

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 |
| Supporting Document | Health - Actuarial Justification | Approved-Closed | Yes |
| Supporting Document | Outline of Coverage | Approved-Closed | Yes |
| Form | DDARTA-2013 | Approved-Closed | Yes |

SERFF Tracking #:

DDAR-128815150

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Delta Dental of Arkansas

TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

DDARTA-2013

Project Name/Number:

/

Form Schedule

Lead Form Number:

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | Readability Score | Attachments |
|----------|-------------------------------|-------------|-------------|-----------|-------------|----------------------|-------------------|-----------------|
| 1 | Approved-Closed 12/17/2012 | DDARTA-2013 | | AEF | Initial | | 0.000 | DDARTA-2013.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 |



Delta Dental of Arkansas
P.O. Box 646
Jacksonville, AR 72078

Delta Dental Individual and Family Application

Plan Number INARTA001
Rates effective 1/1/13 - 12/31/13

| Requested Effective Date | | |
|--------------------------|-----|------|
| Month | Day | Year |

Applicant Name _____ Date of Birth _____ Sex _____
 Mailing Address _____ City _____ State _____ Zip _____
 Social Security # _____ E-mail _____ Phone # _____

Plan Selection (Choose one) **Dental Plan ONLY** **Dental + Vision Plan**
 Individual Individual & Spouse Individual & Child(ren) Individual, Spouse & Children

List all dependents to be enrolled

Spouse's Name _____ Sex _____ Date of Birth (DOB) _____
 Child's Name _____ Relationship _____ Sex _____ DOB _____
 Child's Name _____ Relationship _____ Sex _____ DOB _____
 Child's Name _____ Relationship _____ Sex _____ DOB _____

Will this replace existing dental coverage? Yes No **If Yes, submit copy of current coverage & effective dates.**
 Do all proposed insureds reside in Arkansas? Yes No If no, provide reason: _____

Payment Method **Payment is made via Electronic Funds Transfer ONLY, DO NOT SEND A LIVE CHECK**

| | |
|---|---|
| Bank Draft (EFT): <input type="checkbox"/> Monthly <input type="checkbox"/> Annually | Credit Card: <input type="checkbox"/> Monthly <input type="checkbox"/> Annually |
| Bank Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings | Credit Card type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard |
| Bank Routing Number: _____ | Credit Card Number: _____ |
| Bank Account Number: _____ | Credit Card Expiration Date (MM/YYYY): _____ |
| (Please attach a voided check to application) | Credit Card Holder's Name: _____ |
| I authorize Delta Dental Plan of Arkansas (DDAR) and the BANK* indicated above to debit my DDAR premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me (10) ten days' written notice of the bank's termination of this agreement. | Credit Card Billing Address: _____ |
| | Street Address _____ |
| | City _____ State _____ Zip _____ |

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my DDAR coverage, unless DDAR has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.
 Signature of Applicant _____ Date _____

CV2 Number (last 3 digits located in signature block on back of card): _____

TURN OVER

*BANK also applies to Savings and Loan

Policy Effective Date

All Delta Dental policies will have an effective date of the 1st of the month following receipt of completed application and subsequent to the initial premium amount due being drafted from applicant's checking/savings account or credit card payment. Application must be received in our offices by the 15th of the month prior to the requested effective date. (Example: Received by January 15th to be effective February 1st.) Applications received after the 15th of the month will be made effective on the 1st of the following month. (Example: Received on January 16th, will be effective March 1st.)

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.

Applicant Signature _____ Date _____

City in which application was signed: _____, Arkansas

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 and not warranties.

Applicant Signature _____ Date _____

This section to be completed by sales representative

Agent Name (Please Print) Matt Hughes Agency Name _____

Producer# HUG001 Phone Number 479-967-1339

SERFF Tracking #:

DDAR-128815150

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Delta Dental of Arkansas

TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

DDARTA-2013

Project Name/Number:

/

Supporting Document Schedules

| | | Item Status: | Status Date: |
|------------------|---|-----------------|--------------|
| Bypassed - Item: | Flesch Certification | Approved-Closed | 12/17/2012 |
| Bypass Reason: | n/a | | |
| | | Item Status: | Status Date: |
| Bypassed - Item: | Application | Approved-Closed | 12/17/2012 |
| Bypass Reason: | n/a | | |
| | | Item Status: | Status Date: |
| Bypassed - Item: | Health - Actuarial Justification | Approved-Closed | 12/17/2012 |
| Bypass Reason: | n/a - rates have already been approved. | | |
| | | Item Status: | Status Date: |
| Bypassed - Item: | Outline of Coverage | Approved-Closed | 12/17/2012 |
| Bypass Reason: | n/a | | |