Small Business Service Bureau, Inc.®

Delta Dental
(ACA Compliant)

SBSB Group Dental Insurance Program for Sole-Proprietors and Small Employers in Massachusetts

Welcome!

Enrollment in a Delta Dental insurance plan of your choice is simple – ***only 2 easy steps***. Our Benefit Specialists are available to assist you and all information is confidential.

Step 1: Apply for Delta Dental insurance by submitting the following to SBSB

___ Completed applicable Delta Dental Employer Enrollment Form
(Small group and voluntary plans have separate enrollment forms)

___ Waiver of Coverage Form for each employee opting out of your group dental insurance plan

___ Include Proof of Business Documentation **(choose at least 1)**

- Tax Documentation: Schedule C, WR1 SE

___ Complete the SBSB Membership Application

Step 2: Submit the first month premium and SBSB Annual Membership Dues ($85 for 1-4 employees; $125 for 5+ employees) payable to SBSB.

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872

or scan and email to:
enroll@sbsb.com

All groups subject to dental plan eligibility and underwriting requirements.
All enrollment documents, including the employee's enrollment form, must be completed, signed, dated, and submitted to the Small Business Service Bureau, Inc. prior to the desired effective date.

Join SBSB!
A Big PLUS for Small Business Success!

Member Information

Business Name _____

Name of Owner/Operator ☐ Mr. ☐ Mrs. ☐ Ms.

_____

FIRST NAME MIDDLE INITIAL LAST NAME

_____

TITLE DATE OF BIRTH

Business Address

_____

STREET (NO P.O. BOXES)

_____

CITY STATE ZIP

Mailing Address (if different from street address above)

_____

STREET / P.O. BOX

_____

CITY STATE ZIP

Is your business address the same as your home address?

☐ Yes ☐ No Do you: ☐ Rent ☐ Own ☐ Lease?

Business Telephone (_____) _____

Home Telephone (_____) _____

Fax No. (_____) _____

E-mail _____

Number of Full-Time Employees _____

Description of Business: _____

_____

EXAMPLES: ACCOUNTING, LAW, RETAIL CLOTHING SALES, COMPUTER CONSULTING, ETC.)

Business Structure (check one)

☐ Corporation ☐ Sole Proprietorship
☐ Partnership ☐ Subchapter S

Does your company have a probationary period for new employees? ☐ No ☐ Yes If yes, what is it? _____

_____

AUTHORIZED SIGNATURE **TITLE**

/ /

_____

PRINT NAME **DATE**

Please use the SBSB return-addressed envelope provided to submit your application(s).

☐ **Yes, I want to save money on group insurance and other benefits for my small business!**

Complete this section only if applying for health insurance through SBSB.

Health Insurance Effective Date Desired / /

If you are applying for health insurance, do not cancel any insurance until you are certain your new coverage is in effect.

I hereby certify and attest the information provided herein is true and complete to the best of my knowledge, and that I have the legal authority to execute this document on behalf of the company named herein. I certify that 100% of eligible people who are not covered by a spouse, parent or Medicare are enrolled in the SBSB Health Insurance Program. Furthermore, I certify that all current and future employees to be enrolled actively work full-time, as defined by state and federal laws, for financial compensation. I understand all health coverage becomes effective upon the approval of the provider or carrier. I further state I am aware the health provider retains the right to terminate coverage at any time if the statements made herein are not true and complete.

For information or assistance with this application, call an SBSB Membership Representative Toll Free at

1-800-472-7199.

Small Business Service Bureau, Inc.

A National Membership Organization for Small Business
38 Austin Street • P.O. Box 15014 • Worcester, MA 01615-0014

FOR SBSB USE ONLY

DATE _____ 090 _____ 260 _____ 400 _____

250 _____ 210 _____ 490 _____ 410 _____

240 _____ INITIAL BILL _____ EFF. DATE _____

REASON _____

Small Business Service Bureau, Inc.®

DELTA DENTAL
Delta Dental Plan of Massachusetts

Company Name: _____

Broker Name:_____ **Broker Phone #:** _____ **BR#:** _____
(if applicable)

SBSB Delta Dental Program - April 2020

Dental Products Including ACA Mandated Pediatric Coverage - Rates subject to change

Plan Name	Employer Group Size	Network	Benefits	Monthly Premium	Selection *1 plan per group*
Premier National $1,500 EHB ***Rolling Renewal***	2+ Enrolled	Delta Dental Premier with National Coverage	Preventative 100% Basic 80% Major 50% Deductible $50 Individual/$150 Family $1,500 Calendar Year Maximum age 19+ Out of Pocket Maximum/$350 for age <19 Medically Necessary Orthodonture 50%	Single $68.84 Family $172.52	❑
Premier National $1,000 EHB ***Rolling Renewal***	2+ Enrolled	Delta Dental Premier with National Coverage	Preventative 100% Basic 80% Major 50% Deductible $50 Individual/$150 Family $1,000 Calendar Year Maximum age 19+ Out of Pocket Maximum/$350 for age <19 Medically Necessary Orthodonture 50%	Single $65.86 Family $164.56	❑

PLEASE COMPLETE EMPLOYER ENROLLMENT APPLICATION AND CENSUS

Employer Enrollment Application and Census

Company Name _____

Company Address _____

Phone Number _____ Email Address _____

Contact Person _____

Total # of Employees _____ SIC Code _____

Total # of Eligible Employees _____ Effective Date of Coverage _____

Employee Name	Date of Birth	Enroll/Waiver**	Date of Hire	Full/Part Time (Hours Worked)
1				
2				
3				
4				
5				
6				
7				

Rates and benefits subject to change
***If yes, please include a completed waiver of coverage form.*

Employer Certification & Eligibility Guidelines

1. I hereby certify that my company is a Massachusetts based employer actively engaged in business and attest the information provided above is true and complete to the best of my knowledge and that I have the legal authority to execute this document on behalf of the company named above. I understand all dental coverage becomes effective upon the approval of the provider or carrier.
2. I further state that I am aware the dental plan retains the right to terminate coverage at any time if the statements made herein are not true and complete.
3. I appoint Small Business Insurance Agency, Inc. as the broker of record for the dental plan I have selected above and hereby authorize SBSB to notify the dental plan of this appointment.
4. I certify all current and future employees to be enrolled in the SBSB Group Dental Program actively work for financial compensation on a full-time basis of 20 hours per week.
5. I certify that my company contributes at least 50% towards the single and family premium rate.
6. New Hires: a new employee must become effective within 30 days from the first date of employment.

Please Note:

Delta Dental Plan requires 100% participation for groups of 2-9 lives; 90% participation for groups of 10-49. Delta Voluntary Plan available to groups with 1 participating.

Signed: _____ Date: _____
Authorized Company Representative

Name: _____
Please Print

All groups subject to dental plan eligibility and underwriting requirements. All enrollment documents, including the employee's application, must be completed, signed, dated, and submitted to SBSB five (5) business days prior to the desired effective date.

If you have any questions, please contact SBSB at 1-800-472-7199.

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Worcester, MA 01615-0014

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DELTA DENTAL®
Delta Dental Plan of Massachusetts

C/O **Small Business Service Bureau, Inc.**
38 Austin Street, P.O. Box 15014, Worcester, MA 01615-0014

ENROLLMENT FORM

PLEASE PRINT OR TYPE –
BE SURE FORM IS COMPLETED IN FULL TO ENSURE ENROLLMENT
PLEASE RETURN COMPLETED FORM TO SMALL BUSINESS SERVICE BUREAU, INC.

1. GROUP NAME:	2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER

5. SOCIAL SECURITY NO.	6. LAST NAME (Subscriber):	7. FIRST NAME:	8. DOB:	9. SEX:

10. HOME ADDRESS	11. CITY:	12. STATE:	13. ZIP:

PLAN SELECTION

14. PLAN: Select plan you are enrolling in:

☐ ***Premier National $1,000 EHB*** ☐ ***Premier National $1,500 EHB***

PLEASE LIST ALL DEPENDENT(S) COVERED UNDER YOUR POLICY

15. FIRST NAME	16. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	18. SEX M/F	19. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT	DELTACARE PLAN ONLY		
					20. CHOOSE A PCD FOR EACH COVERED INDIVIDUAL	21. PROVIDER #	22. DO YOU CURRENTLY USE THIS DENTIST?
SUBSCRIBER							
SPOUSE							
CHILDREN							

23. REASON FOR SUBMISSION (CHECK ONE)

- ☐ New Addition
  - ☐ Individual ☐ Individual + 1 ☐ Family
- ☐ Termination: Date of termination _____
- ☐ Add dependent to family
- ☐ Reinstatement
- ☐ Name / address change
- ☐ Remove dependent for student status
- ☐ Transfer from sublocation_____ to _____
- ☐ Status change (must be 1st of month)
  - ☐ Individual to Family ☐ Individual + 1 ☐ Family to Individual
- ☐ Cobra – Reinstatement of subscriber
- ☐ Cobra – new addition of dependent formerly covered under ID#_____
  Number of months Cobra eligible _____
- ☐ Cobra – reinstatement – transfer to Cobra sublocation

24. COORDINATION OF BENEFITS

Are ☐ you OR ☐ any other family member covered by another dental plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____.

OTHER DENTAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

25. Are ☐ you OR ☐ any other family member covered by another medical plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____.

OTHER MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental Plan of Massachusetts. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

26. Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____

Please remit original to SBSB • Make one copy for employer records and one copy to use as temporary I.D. card.

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Waiver/Verification of Alternative Coverage

I,_____ , certify that I am an employee of and that I am eligible for group dental care coverage through_____ , my employer. I also certify that I am waiving my right to group dental care coverage through my employer at this time because I have chosen dental care coverage through ***(Check box that applies):***

❑ Parent ❑ Spouse ❑ Medicare ❑ Alternate group dental program

Parent's / Spouse's Name: _____

Parent's / Spouse's Company: _____

Current Dental Plan: _____

Dental Plan Group Number:_____

Dental Plan Subscriber Number: _____

Name *(please print)*

Signature Date

Signature of Authorized Company Representative Date

Please call an SBSB Membership Representative at 1-800-472-7199 with any questions.

Return with the completed census and required documents to:
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