

# Electronic Group Information Form 'How To' Guide

October 2021

Roosevelt  
simple. seamless. smart.

# Group Information Form

## Welcome to Delta Dental

Thank you for taking a few moments  
to fill out this Group Information Form.

This site is optimized for [Microsoft Edge](#), [Google Chrome](#) and [Apple Safari](#).

[FireFox](#), [Opera](#), [Vivaldi](#) and other HTML5 browsers *may* also work,  
but with decreased performance and slower speeds.

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[Click Here for the Form](#)

1. Click “Click Here for the From” to open the Group Information Form

## Group Information

Page Help ⓘ

Next Page

\* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

\* Physical Address

\* City

\* State

\* Zip Code #####

\* County

**Please Note:** P.O. Boxes are not acceptable for client location.

\* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

Save and Finish Later

Next Page

## Form Progress

**Group Information**

- Group Contact Information
- Benefit Manager Toolkit
- Prior Carrier
- Subgroup Information
- Eligibility Age Limits
- Coordination of Benefits
- Subscriber Definition
- Member Waiting Period
- Termination Language
- HIPAA Group Plan Cert.
- Summary - Form Data
- Summary - Documents
- Submission

(14 pages)

2. Complete all fields on the Group Information Page

## Group Information

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\* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

\* Physical Address

\* City

\* State

\* Zip Code #####

\* County

**Please Note:** P.O. Boxes are not acceptable for client location.

\* Group Tax Identification/EIN #: (XXXXXXXXXX)

Save and Finish Later

Next Page

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

## Form Progress

**Group Information**

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- Submission

(14 pages)

3. Review the non-editable gray fields and contact your Sales Rep if anything is incorrect

**Group Information** Page Help ⓘ Next Page

\* Legal Business Name  
  
*Enter the Company Name as you would like it to appear on the contract.*

\* Physical Address

\* City  \* State

\* Zip Code #####  \* County

*Please Note: P.O. Boxes are not acceptable for client location.*

\* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

Save and Finish Later Next Page

Form Progress

- Group Information**
- Group Contact Information
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- Prior Carrier
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- Eligibility Age Limits
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(14 pages)

4. At any point while filling out the form, you can save and finish the form later. Use the same link to access the form again

## Group Information

Page Help ⓘ

Next Page

\* Legal Business Name

Enter the Company Name as you would like it to appear on the contract.

\* Physical Address

\* City

\* State

(Choose) ▼

\* Zip Code #####

\* County

**Please Note:** P.O. Boxes are not acceptable for client location.

\* Group Tax Identification/EIN #: (XXXXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

Save and Finish Later

Next Page

## Form Progress

### Group Information

- Group Contact Information
- Benefit Manager Toolkit
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- Submission

(14 pages)

5. Click “Next Page” to move to the next page. Moving to the next page will also save your information

### Contact Type Selection

- Add contacts in the below section by clicking the add contact button
- Once all contact(s) have been added, please select the Contact Type for your contact
- Only one contact name is allowed per Contact Type

### Contact Role Definitions:

**General Contact** - This contact will receive a second collection letter if the Billing Contact collection letter goes unanswered.

**Renewal Contact** - This contact will receive the contract and renewal documents. A Renewal Contact is required for documents, if there is not a renewal contact listed the address on the documents will print blank.

**Billing Contact** - This contact will receive bills and other materials related to billing. We must have an email address for this contact to send bills via email. This contact also receives an email notification that the invoice is available on Benefit Manager Toolkit (BMT). However, if the client receives their Delta Dental bill in the mail, this is the name and address of the individual receiving that information.

**Materials Contact** - This contact will receive group materials, such as pamphlets, certificates, summaries, etc. Note: A PO Box cannot be used for the materials contact, and a street address must be entered for this contact type.

**Mailing Contact** - This contact will receive general, mass mailing information.

**Overage Dependent Contact** - This contact will receive the email notification that the overage dependent report is ready to be viewed in BMT. This contact type requires an email address.

6. Review the contact role definitions and scroll down to enter contacts



Contacts + Add Contact

Name	Address	Preferred Ph#/Email
Legend:  Edit  Delete  Set All Roles		

Roles

- \* General  
Choose... ▾
- \* Renewal  
Choose... ▾
- \* Billing  
Choose... ▾
- \* Mailing  
Choose... ▾
- \* Materials (no P.O. Boxes) ?  
Choose... ▾
- \* Overage Dependent  
Choose... ▾

\* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No ▾

Save and Finish Later

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Next Page

7. Use the green “Add Contact” button to add a contact

Group Contact Information

- Add contact
- Once all
- Only one

General Contact  
Renewal Contact  
there is not a re  
Billing Contact  
contact to send  
Toolkit (BMT). F  
receiving that in  
Materials Cont  
cannot be used  
Mailing Contac  
Overage Depen  
viewed in BMT.

### Edit Contact

**Special Note: Contacts for the Materials Role may not have a P.O. Box.**

**Contact Name:**

Salutation  \*First Name  \*Last Name  Suffix

Title

**Address Details:**

Street  Apt/Suite

City  State  Zip #####

**Contact Methods:**

Required Method  \*Preferred Work Email

Second Method

- Progress
- Group Information 1 Issues
  - Group Contact Information**
  - Benefit Manager Toolkit
  - Prior Carrier
  - Eligibility Age Limits
  - Coordination of Benefits
  - Subscriber Definition
  - Member Waiting Period
  - Termination Language
  - HIPAA Group Plan Cert.
  - Summary - Form Data
  - Summary - Documents
  - Submission

Contacts

Name

Legend: Edit Delete Set All Roles

\*Renewal

## Edit Contact

**Special Note: Contacts for the Materials Role may not have a P.O. Box.**

### Contact Name:

Salutation	* First Name	* Last Name	Suffix
Select... ▾	<input type="text"/>	<input type="text"/>	<input type="text"/>
Title			
<input type="text"/>			

### Address Details:

Street	Apt/Suite	
<input type="text" value="123 Tester Street"/>	<input type="text"/>	
City	State	Zip #####
<input type="text" value="Middle"/>	<input td="" type="text" value="Michigan" ▾<=""/> <td><input type="text" value="12345"/></td>	<input type="text" value="12345"/>

### Contact Methods:

Required Method	* Preferred Work Email
<input type="text" value="Work Email"/>	<input type="text"/>
Second Method	

Cancel

Save

9. The address will default to the Group address. Confirm that this is accurate or update to the correct address

### Edit Contact

Special Note: Contacts for the Materials Role may not have a P.O. Box.

#### Contact Name:

Salutation \* First Name \* Last Name Suffix

Select...

Title

#### Address Details:

Street Apt/Suite

123 Tester Street

City State Zip #####

Middle Michigan  12345

#### Contact Methods:

Required Method \* Preferred Work Email

Work Email

Cancel Save

10. Enter the contact's email address, and add a secondary contact method if desired

Group Contact Information

- Add contact
- Once all
- Only one

General Contact  
Renewal Contact  
there is not a re  
Billing Contact  
contact to send  
Toolkit (BMT). F  
receiving that in  
Materials Cont  
cannot be used  
Mailing Contac  
Overage Depen  
viewed in BMT.

Contacts

Name

Legend: Edit Delete Set All Roles

### Edit Contact

**Special Note: Contacts for the Materials Role may not have a P.O. Box.**

**Contact Name:**

Salutation  \* First Name  \* Last Name  Suffix   
Title

**Address Details:**







Street  Apt/Suite   
City  State  Zip #####




**Contact Methods:**

Required Method  \* Preferred Work Email   
Second Method


11. Click "Save" to save the contact. You will be able to make edits to any saved contacts

Contacts + Add Contact

Name	Address	Prefered Ph#/Email	
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:  Edit  Delete  Set All Roles

Roles

- \* General  
Choose...
- \* Renewal  
Choose...
- \* Billing  
Choose...
- \* Mailing  
Choose...
- \* Materials (no P.O. Boxes)   
Choose...
- \* Overage Dependent  
Choose...

\* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No







Save and Finish Later




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12. To edit an existing contact, click the pencil icon. To delete a contact, click the garbage can icon. To set that contact as all roles, click the arrows

Contacts + Add Contact

Name	Address	Preferred Ph#/Email	
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:  Edit  Delete  Set All Roles

Roles

- \* General
  - John Smith
- \* Renewal
  - Jane Brown
- \* Billing
  - John Smith
- \* Mailing
  - John Smith
- \* Materials (no P.O. Boxes)
  - John Smith
  - Choose...
  - John Smith
  - Jane Brown

\* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No

Save and Finish Later

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13. Set a contact to each role by using the arrows or the drop down under each role

Contacts + Add Contact

Name	Address	Prefered Ph#/Email	
John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	

Legend: Edit Delete Set All Roles

Roles

- \* General  
Choose...
- \* Renewal  
Choose...
- \* Billing  
Choose...
- \* Mailing  
Choose...
- \* Materials (no P.O. Boxes)   
Choose...
- \* Overage Dependent  
Choose...

\* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

No







Save and Finish Later




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14. Indicate if you need additional emails notified that a bill is available to be viewed online



John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:  Edit  Delete  Set All Roles

John Smith

\* Renewal  
Jane Brown

\* Billing  
John Smith

\* Mailing  
John Smith

\* Materials (no P.O. Boxes)   
John Smith

\* Overage Dependent  
John Smith

\* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

Yes

\* Additional Billing Emails (please enter with a comma in between each email, i.e. billing@company.com, jane@company.com).







accounting@company.com, admin@company.com




Save and Finish Later

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15. If yes, add the billing emails that should be notified with a comma between each one

John Smith	123 Main St. Lansing, MI 00000	johnsmith@company.com	  
Jane Brown	123 Main St. Lansing, MI 00000	janebrown@company.com	  

Legend:  Edit  Delete  Set All Roles

John Smith

\* Renewal  
Jane Brown

\* Billing  
John Smith

\* Mailing  
John Smith

\* Materials (no P.O. Boxes)   
John Smith

\* Overage Dependent  
John Smith

\* Do you need additional emails notified that a bill has been produced and is available to be viewed online?

Yes

\* Additional Billing Emails (please enter with a comma in between each email, i.e. billing@company.com, jane@company.com).

accounting@company.com, admin@company.com

Save and Finish Later

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16. Once complete, click “Next Page” to move to the next page

Select one individual within your company to be your Group Administrator and complete the information below. This administrator will be able to create and maintain your accounts as well as create BMT user accounts for additional individuals within your company. Delta Dental will send your administrator an email with registration information and additional instructions.

***BMT Administrator must be an employee of the client***

***Please define who will be the administrator for your accounts:***

\* Administrator's First Name:

\* Administrator's Last Name :

\* Administrator's Title

\* Email:

\* Phone Number: XXX-XXX-XXXX

## 17. Complete each field to add the BMT administrator

*Note: the BMT administrator must be an individual within the company*

\* I authorize that the assigned Agent/Agency (including General Agents) requires access to the Benefit Manager Toolkit as indicated.

[PLEASE CLICK HERE TO GET A PREVIEW OF THE BENEFIT MANAGER TOOLKIT](#)

### **What is BMT?**

With the Benefit Manager Toolkit® (BMT), benefit managers and third-party administrators can:

- Get real-time benefit and eligibility information 24/7
- Access billing details
- Manage your groups eligibility by entering, editing and terminating members
- Streamline your benefits management process
- Download dentist directories in a printable format

Save and Finish Later

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18. If you have an agent, indicate if you want to give your assigned agent/agency access to BMT

\* I authorize that the assigned Agent/Agency (including General Agents) requires access to the Benefit Manager Toolkit as indicated.

Yes

[PLEASE CLICK HERE TO GET A PREVIEW OF THE BENEFIT MANAGER TOOLKIT](#)

### **What is BMT?**

With the Benefit Manager Toolkit® (BMT), benefit managers and third-party administrators can:

- Get real-time benefit and eligibility information 24/7
- Access billing details
- Manage your groups eligibility by entering, editing and terminating members
- Streamline your benefits management process
- Download dentist directories in a printable format

Save and Finish Later

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19. Once complete, click “Next Page” to move to the next page

\* Do you have a prior carrier?

\* Prior carrier name:

*Please attach a copy of your invoice or benefit summary from your prior carrier.*

Prior carrier documents

No Files Attached.

 Click to Upload a File \*

Save and Finish

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20. If you have Prior Carrier, type in the prior carrier's name and attach a copy of your invoice or benefit summary

## Prior Carrier

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\*Do you have a prior carrier?

No 

Save and Finish

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21. If you do not have a Prior Carrier, select “No” and move on to the next page

## Subgroup Information

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*Please enter your Plan Information and the associated Subgroup information in the section below.*

*Information may have been pre-filled by your Sales Representative.  
You can modify the Plan name and Subgroup names and numbers below.*

*Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example: Cobra members, retirees, locations, etc.*

*See downloadable document for Subgroup structure examples*

### Plans

High Plan

 Edit Plan Name

\* Subgroup #   \* Subgroup Name

 Add

0001

Subgroup name



22. Review the plans and subgroups that have been added for your group



## Subgroup Information

Page Help 

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Next Page

*Please enter your Plan Information and the associated Subgroup information in the section below.*

*Information may have been pre-filled by your Sales Representative.  
You can modify the Plan name and Subgroup names and numbers below.*

*Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example:Cobra members, retirees, locations, etc.*

*See downloadable document for Subgroup structure examples*

### Plans

High Plan

 Edit Plan Name

\* Subgroup #   \* Subgroup Name

 Add

0001

Subgroup name



23. Edit the plan name with the “Edit Plan Name” button or click into the subgroup name or subgroup number to edit the subgroup name or subgroup number

## Subgroup Information

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*Please enter your Plan Information and the associated Subgroup information in the section below.*

*Information may have been pre-filled by your Sales Representative.  
You can modify the Plan name and Subgroup names and numbers below.*

*Additional Subgroups are only needed to track employee segments separately for billing and reporting purposes. Example: Cobra members, retirees, locations, etc.*

*See downloadable document for Subgroup structure examples*

### Plans

High Plan

 Edit Plan Name

\* Subgroup # \* Subgroup Name

 Add

0001

Subgroup name



24. If needed, add a subgroup with the green “Add” button or delete a subgroup with the red trash can button

## Plans

High Plan

 Edit Plan Name

\* Subgroup # \* Subgroup Name

 Add

0001

Subgroup name



\* Is Subgroup contact information different from what was previously entered?

No

Save and Finish Later

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25. Indicate if the subgroups have different contact information (address, etc) than the group

0001

Subgroup name



\* Is Subgroup contact information different from what was previously entered?

Yes

[Click here to access sample Subgroup spreadsheet. Once updated please upload below.](#)

Please upload Subgroup spreadsheet if applicable here.

No Files Attached.



Upload Files

Or drop files

\*

Save and Finish Later

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26. If the subgroups have different contact information, upload a subgroup spreadsheet that includes contact and other information by subgroup

0001

Subgroup name



\* Is Subgroup contact information different from what was previously entered?

Yes



[Click here to access sample Subgroup spreadsheet. Once updated please upload below.](#)

Please upload Subgroup spreadsheet if applicable here.

No Files Attached.



Upload Files

Or drop files

\*

Save and Finish Later

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27. Once complete, click “Next Page” to move to the next page

## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

Yes

\* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

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28. Indicate if dependent children are covered to age 26

## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

Yes

\* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

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29. If dependent children are covered to age 26, select when coverage ends

## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

\* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

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30. If dependent children are not covered to age 26, indicate ages for each dependent



## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

19

20

21

22

23

24

25

26

IRS Max Age

23

\* When does dependent child(ren) stop being a dependent?

End of Year that the age limit is reached

Save and Finish Later

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31. The age limits are selected from each drop down. The Child Max Age selected should be lower than the student max age, which should be lower than the IRS max age

## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

\* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

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32. Once age limits have been indicated, select when coverage ends

## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

\* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

(Choose)

To Birthdate that the age limit above has been reached

End Of Month that the age limit above has been reached

End of Year that the age limit above has been reached

End of Benefit Period that the age limit above has been reached

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33. Select one of the coverage end options from the drop down list

## Eligibility Age Limits for Dependent Child(ren)

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\* Are your dependent children covered to age 26?

No

Please indicate the age limits below:

Child Max Age (without student status)

20

Student Max Age

21

IRS Max Age

23

\* When does dependent child(ren) coverage end?

End of Year that the age limit above has been reached

Save and Finish Later

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34. Once complete, click “Next Page” to move to the next page

\* Payment Option Type:

Standard

*For a definition of payment types, see Page Help*

\* Support Internal COB - Plan will allow spouses with same employer to cover each other:

No

*For additional information on Internal COB, see Page Help*

\* Support External COB - Plan will allow spouses with different employers to cover each other:

Yes

*For additional information on External COB, see Page Help*

\* Domestic Partner Coverage:

No

[Save and Finish Later](#)

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## PAGE HELP

Please fill out each field to the best of your ability. You will not be able to move forward until you have completed each required field. Defaults have been selected for the most common answer, but you may change any selection on the defaulted field. Please contact your Sales Rep if you have any questions throughout the process.

Coordination of Benefits (COB) is a procedure for paying health care expenses when people are covered by more than one plan. The goal of COB is to make sure the combined payments of the plan do not exceed the amount of your actual bills.

- ***This is internal COB "No" definition: Coordination of Benefits*** - If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.
- ***This is internal COB "Yes" definition: Coordination of Benefits*** - If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your dependent Children may be enrolled on both you and your Spouse's application as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Support External COB: Plan will allow spouses with different employers can cover each other.

Payment Option Types definitions:

Close

36. The Page Help section has definitions of COB terms. Click "Close" to return to the form

## Coordination of Benefits (COB) Processing Information

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\* Payment Option Type:

Standard

*For a definition of payment types, see Page Help*

\* Support Internal COB - Plan will allow spouses with same employer to cover each other:

No

*For additional information on Internal COB, see Page Help*

\* Support External COB - Plan will allow spouses with different employers to cover each other:

Yes

*For additional information on External COB, see Page Help*

\* Domestic Partner Coverage:

No

Save and Finish Later

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37. Once complete, click “Next Page” to move to the next page

## Subscriber Definition

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*The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page.*

**Subscriber Definition Example:** All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable.

\*Who is eligible for benefits?

All full-time employees of the Contractor working at least X hours per



\* Minimum number of hours per week full-time employees who choose the dental plan and COBRA enrollees if applicable:

30



38. Indicate who is eligible for benefits and the minimum number of hours per week needed for full-time employees to enroll in dental benefits



*The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page.*

**Subscriber Definition Example:** All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable.

\*Who is eligible for benefits?

All full-time employees of the Contractor working at least X hours per

(Choose)

All full-time employees of the Contractor working at least X hours per

Other

39. If you need to create your own definition, select “Other”

*The subscriber definition determines who is eligible for benefits. If this definition is different by Subgroup please add it to the downloadable spreadsheet found on the Subgroup Information page.*

**Subscriber Definition Example:** All full time employees of the Contractor working at least 30 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Reconciliation Act of 1985) enrollees, if applicable.

\*Who is eligible for benefits?

Other

\*Other subscriber definition:

Write definition here

40. Write in the group's desired subscriber definition in the other box

### Employer Participation Verification

*I verify that all of the individuals eligible for dental coverage have been given the opportunity to enroll in the dental plan offered by Delta Dental. For the undersigned employer, I certify that the number of eligible and enrolled employees for this dental plan of this date:*

\* Number of Full-Time Employees ELIGIBLE for Dental:

\* Number of Full-Time Employees ENROLLED for Dental:

\* Number of Part-Time Employees ELIGIBLE for Dental:

\* Number of Part-Time Employees ENROLLED for Dental:

\* Number of Retired Employees ELIGIBLE for Dental:

\* Number of Retired Employees ENROLLED for Dental:

*If a segment has members but they are not eligible for coverage, enter zero for the number eligible.*

Save and Finish Later

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41. Review the Employer Participation Verification section and input the number of employees (full time, part-time, and retired) eligible and enrolled for Dental. Once complete, click “Next Page”

## New Employee/Member Waiting Period

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\* When does coverage begin for a new employee?

Coverage begins on the date of hire



Save and Finish Later

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42. Indicate when coverage begins for a new employee

## New Employee/Member Waiting Period

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\* When does coverage begin for a new employee?

Coverage begins on the date of hire

(Choose)

Coverage begins on the date of hire

Coverage begins X days after hire

Coverage begins in the first day of the month following X days of employment

Coverage begins on the first day of the month following the date of hire

Other (please fill in below)

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43. Select an option from the drop down or pick Other to add your own definition


## New Employee/Member Waiting Period

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\* When does coverage begin for a new employee?

Other (please fill in below) 

\* Other waiting period definition:

Write definition here

Save and Finish Later

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44. If other, write a definition in the other box

## New Employee/Member Waiting Period

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\* When does coverage begin for a new employee?

Coverage begins on the date of hire

Save and Finish Later

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45. Once complete, click “Next Page” to move to the next page

## Termination Language

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\* When an employee is no longer at your organization, when does their coverage end?

At end of the month following termination

Save and Finish Later

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46. Indicate when coverage ends when an employee is no longer with your organization




## Termination Language

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\*When an employee is no longer at your organization, when does their coverage end?

Other 

(Choose)

At end of the month following termination

Date of termination

Other

Save and Finish Later

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47. Select an option from the drop down or pick “Other” to add your own definition

## Termination Language

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\* When an employee is no longer at your organization, when does their coverage end?

Other

\* Other Termination Language:

Write other language here

Save and Finish Later

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48. If other, write in your own termination language

## Termination Language

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\* When an employee is no longer at your organization, when does their coverage end?

At end of the month following termination

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49. Once complete, click “Next Page” to move to the next page

# Group Information Form (eGIF)

## HIPAA Group Plan Certification

PDF 

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The [Client Name Goes Here] Group Health Plan ("Plan", through its fiduciary, does hereby certify to the following:

1. That the Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
2. That the Plan documents you distribute to employees informing them about their benefits or the Plan documents you are legally required to maintain for your employee benefits plans have been amended, as required by 45 CFR 164.504(f) of HIPAA, to incorporate the following provisions and you, as the Plan Sponsor, agreed to:
  - a. Not use or further disclose health information protected under HIPAA ("PHI") other than as permitted or required by the plan documents or as required by law;
  - b. Ensure that any agents, including subcontractors, to whom you provide PHI agree to the same restrictions and conditions that apply to you with respect to such information;
  - c. Not use or disclose PHI for employment-related actions and decisions;
  - d. Not use or disclose PHI in connection with any other benefit or employee benefit plan;
  - e. Report to Plan's designee any PHI use or disclosure that you become aware of that is inconsistent with the uses or disclosures provided for;
  - f. Make PHI available to an individual based on HIPAA's access requirements;
  - g. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
  - h. Make available the information required to provide and accounting of disclosures;
  - i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
  - j. Ensure the adequate separation between the Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and
- k. If feasible, return or destroy all PHI received from Plan that you, as Plan Sponsor, still maintain any form and retain no copies of such PHI when no longer needed for the specific disclosure purpose. If return or destruction is not feasible, you will limit further uses and disclosures to those purposes that make the return destruction infeasible.

3. The undersigned further certifies that he or she has the authority to sign on behalf of the Plan.

Accept 

Printed Name of Plan Fiduciary Representative:

Test 

***The field above does not qualify as an electronic signature;  
a signature form must be downloaded, signed, and uploaded below.***

[Click here to download Signature Form. Once signed please click the attach file button below to complete the HIPAA Group Plan Certification.](#)

50. Note for a Risk Group you will need to accept or reject HIPAA agreement. If accepted t, you must download, sign, and upload the form.

## Summary - Form Data

Page Help 

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**Please review All Information for Accuracy prior to submitting.**

### **Name and Address**

Legal Business Name:

Group Name

Tax ID:

123456789

Address:

123 Main St

City:

Lansing

State:

Michigan

Zip Code:

00000

County:















Ingham

Effective Date:

5/27/2021



### Form Progress

-  Group Information
-  Group Contact Information
-  Benefit Manager Toolkit
-  Prior Carrier
-  Subgroup Information
-  Eligibility Age Limits
-  Coordination of Benefits
-  Subscriber Definition
-  Member Waiting Period
-  Termination Language
-  HIPAA Group Plan Cert.
-  **Summary - Form Data**
-  Summary - Documents
-  Submission

(14 pages )

51. Once you have completed all pages, review the information on the Summary page. You can edit some information from this page, or move back to a previous page to make updates

\* Subgroup # \* Subgroup Name

+ Add

1001

Subgroup name



Plan

 Edit Plan Name

\* Subgroup # \* Subgroup Name

+ Add

2001

Subgroup name



Save and Finish Later

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52. Once complete, click “Next Page” to move to the next page

## Summary -- Attached Documents

Page Help 

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**\*\* Please confirm you have attached all the correct documents to the form below \*\***

*In addition to any documents previously loaded the following document templates are being provided for your convenience but are not required:*

**Enrollment Spreadsheet:** This form is to be completed for each employee (and his/her dependents) that chooses to enroll.

**Enrollment form:** This form is an optional form that can be used for enrollment

**Direct Debit Form:** This form is an optional form if the group would like their monthly premiums withdrawn electronically

*If you choose to fill out any of above documents, please be sure to attach them to your Group Intake Form by using the Upload Document button below.*

[Direct Debit Authorization Form](#)

[Enrollment Form](#)

[Enrollment Spreadsheet](#)

### Form Progress

- Group Information
- Group Contact Information
- Benefit Manager Toolkit
- Prior Carrier
- Subgroup Information
- Eligibility Age Limits
- Coordination of Benefits
- Subscriber Definition
- Member Waiting Period
- Termination Language
- HIPAA Group Plan Cert.
- Summary - Form Data
- Summary - Documents**
- Submission

(14 pages )

53. After all information has been reviewed, attach any documents that need to be included with your Group Information Form. Optional documents are available to be downloaded from this page

*If you choose to fill out any of above documents, please be sure to attach them to your Group Intake Form by using the Upload Document button below.*

[Direct Debit Authorization Form](#)

[Enrollment Form](#)

[Enrollment Spreadsheet](#)

Documents

No Files Attached.

 Upload Files

Or drop files

Save and Finish Later

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- ✓ Subscriber Definition
- ✓ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- Summary - Documents**
- Submission

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54. Upload documents that need to be included with your Group Information Form



*If you choose to fill out any of above documents, please be sure to attach them to your Group Intake Form by using the Upload Document button below.*

[Direct Debit Authorization Form](#)

[Enrollment Form](#)

[Enrollment Spreadsheet](#)

Documents

No Files Attached.

 Upload Files Or drop files

Save and Finish Later

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- ✓ Subscriber Definition
- ✓ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- Summary - Documents**
- Submission

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55. Once complete, click “Next Page” to move to the next page

## Confirmation and Submission

Page Help 1

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If the green "**Finish & Download PDF Copy**" button is enabled, then:

Congratulations, you are now ready to complete this form.

Clicking that button will submit this form to your Sales Representative and automatically open a PDF copy of this form for you to save and keep for future reference.

-----  
Once this form is submitted, your access to this form will *no longer be valid*.  
Your Sales Representative will review your information and may contact you with any question.

Save and Finish Later

Finish & Download PDF Copy

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## Form Progress

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- ⊘ Member Waiting Period
- ✓ Termination Language
- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- ✓ Summary - Documents
- ⊘ **Submission**

1 issues

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56. If the “Finish & Download PDF Copy” button is gray, go back to the page with an issue to complete it

**Confirmation and Submission**

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If the green "**Finish & Download PDF Copy**" button is enabled, then:

Congratulations, you are now ready to complete this form.

Clicking that button will submit this form to your Sales Representative and automatically open a PDF copy of this form for you to save and keep for future reference.

-----

Once this form is submitted, your access to this form will *no longer be valid*. Your Sales Representative will review your information and may contact you with any question.

Save and Finish Later **Finish & Download PDF Copy** Previous Page

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- ✓ HIPAA Group Plan Cert.
- ✓ Summary - Form Data
- ✓ Summary - Documents
- **Submission**

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57. Once all pages have been completed, the “Finish & Download PDF Copy” is green, and you have all green checks on the right-hand menu, you are ready to submit

## Confirmation and Submission

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If the green "**Finish & Download PDF Copy**" button is enabled, then:

Congratulations, you are now ready to complete this form.

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## Form Progress

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- ✓ Summary - Documents
- **Submission**

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58. If you are not ready to submit, use the "Save and Finish Later" button to save all of your information. You can return to the form at any time using the same link

## Confirmation and Submission

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If the green "**Finish & Download PDF Copy**" button is enabled, then:

Congratulations, you are now ready to complete this form.

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-----  
Once this form is submitted, your access to this form will *no longer be valid*.  
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Save and Finish Later

**Finish & Download PDF Copy**

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## Form Progress

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59. Once you are ready to submit, click “Finish & Download PDF copy” to submit the form



1



2



3

## Delta Dental's - New Group Process

# Group Information Form (eGIF)

Powered by  
**Roosevelt**

### Group Information

Legal Business Name

*Enter the Company Name as you would like it to appear on the contract.*

Physical Address

City

State

Zip Code #####

County

*Please Note: P.O. Boxes are not acceptable for client location.*

Group Tax Identification/EIN #: (XXXXXXXX)

Group Name:

Plan:

Effective Date:

Contract Length:

Group Type:

Agent Name:

60. You have submitted the Group Information Form. You can now download a PDF of the form for your records. Reach out to your Sales Rep if you have any questions.