GROUP DATA FORM

Delta Dental of Rhode Island
10 Charles Street
Providence, RI 02904
1-800-843-3582
www.deltadentalri.com

Effective January 2014, Delta Dental is requesting the information listed below to verify whether your group's benefit plan will be impacted by the requirements of the Affordable Care Act.

In addition, Delta Dental needs this information to comply with the rating methodologies on file with the Office of the Health Insurance Commissioner (OHIC).

ACCOUNT INFORMATION

Group Name:	Group #:
Company Representative Name:	Company Representative Email Address:
Renewal Month:	# of Benefit Eligible Employees:
# of Spousal Waivers*:	SIC Code:

* Waivers due to coverage under another dental plan.

EMPLOYER CONTRIBUTION

Please indicate ($) or (%) amount for each rate tier.

	Individual	Two Person	EE/Child(ren)	Family
$ Amount of Employer Contribution (monthly)				
OR				
% Amount of Employer Contribution				

NOTES

Please provide any additional information regarding dental contributions.

SIGN HERE

Company Representative/Broker Representative Name: _____ Title: _____

Signature: _____ Date: _____