DELTA DENTAL®

Covered Under Two Dental Plans?

DUAL COVERAGE

"Dual coverage" refers to when your dental treatment is covered by more than one dental benefits plan. This doesn't mean your coverage is doubled, but by coordinating your benefits, we may be able to reduce your out-of-pocket expenses.

Delta Dental of Kansas works with the other insurance company (i.e. Aetna, Cigna, Blue Cross Blue Shield, another Delta Dental) to coordinate your benefits (COB). COB is the process insurance companies follow to determine how much each dental plan you are covered by will pay.

HOW DOES DUAL COVERAGE WORK?

One plan will pay your claims first (primary plan) and the secondary plan benefits will apply to the remaining balance. The plan that covers you as an enrollee (or the policyholder) is the primary plan and the plan covering you as a dependent would be the secondary plan.

For example, if your dentist charges $100 for a filling and your primary insurance covers fillings at 90 percent, the primary plan would pay the dentist $90. Typically, you'd receive a bill for the remaining $10, but your secondary insurance covers fillings at 80 percent of the cost. The secondary insurance would pay 80 percent, or $80, but because the remaining balance is only $10, the secondary plan would only pay $10 leaving you with no financial responsibility. (example may differ if deductible applies.)

For children, if the child is still living with both biological parents, the primary insurance is determined by the coverage of the parent whose birthday (month and day) comes first. In situations involving separated or divorced parents, this rule may be superseded by a court order that authorizes the responsible party for the child or where one parent has primary custody.

WHAT DO WE NEED FROM YOU?

If you are receiving this form, your dental plan contains a Coordination of Benefits (COB) provision. In order for us to coordinate your benefits with the other dental insurance company, we need you to provide additional information.

Please complete and submit the Dual Coverage Information Request form in any of the following ways:
Email: Scan your form and email it to COB@deltadentalks.com.
Fax: Fax a copy of your form to 316.462.3392
Mail: Send a copy of your form to P.O. Box 789769, Wichita, KS 67278-9773.

Learn more about oral health, using your benefits, member tools and more at **DeltaDentalKS.com/Knowledge**.

Dual Coverage Information Request Form

Your dental plan contains a Coordination of Benefits (COB) provision. By coordinating benefits with your other dental insurance carrier, we may be able to reduce your out-of-pocket expenses for covered services. **Please complete and return this form in the enclosed envelope to our office within 14 days to prevent denial of any pending claims.**

SECTION 1 - DELTA DENTAL OF KANSAS (DDKS) SUBSCRIBER INFORMATION

DDKS Subscriber Name: _____
(Found on your Member ID card)

Member Number: _____
(Found on your Member ID card)

Are you, your spouse or any of your dependents covered by another dental plan?

☐ **Yes** - For You ☐ **Yes** - For Spouse ☐ **Yes** - For Dependents ☐ **No** - If no, sign and return.

If yes to any, complete section 2 and 3 (if appropriate), sign & return.

SECTION 2 - OTHER DENTAL INSURANCE INFORMATION

(If more than one additional plan exists, copy this document and provide information for each additional dental insurance plan covering you and/or your family members.)

Policyholder Information:

Policyholder Name: _____ Policyholder Member ID: _____

Policyholder Date of Birth: _____ Employer: _____

Other Dental Insurance Carrier Information:

Dental Insurance Carrier Name: _____ Group #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Hire Date (Required): _____ Term Date (if applicable): _____

Type of Plan:

☐ Dental - Employer Based ☐ Dental - Self Enrolled ☐ State Funded – Medicaid ☐ Medicare Advantage

☐ Dental Embedded in Medical Policy ☐ Other: Please Explain _____

Who is covered under this dental plan? (check all that apply) ☐ Self ☐ Spouse ☐ Dependent(s)

Name (First and Last)	**Relationship Type** (see options below)	**Start Date of Coverage***

*Date the policyholder was originally eligible for and covered by a dental plan.

If dependent(s) are listed, please select the option that best describes the relationship of the two policyholders:

1. Two biological parents
2. Two legal guardians
3. One biological parent and one legal guardian
4. One biological parent or legal guardian and one step-parent
5. Two step-parents
6. Other, please explain: _____

Dual Coverage Information Request Form

SECTION 2 - OTHER DENTAL INSURANCE INFORMATION (CONT.)

Do both policyholders live at the same address? ☐ Yes ☐ No

Are the policyholders legally married to each other? ☐ Yes ☐ No

If this coverage is provided by a Department of Defense health benefit program, which statement listed below is most applicable?

☐ Full-Time Active Duty ☐ Reserves ☐ Military Retiree ☐ Other: _____

SECTION 3 - SPECIAL SITUATIONS

(Complete this section ONLY when parents are divorced, legally separated, not living together, or there is a court order.)

Is there a court order that determines responsibility for health/dental care coverage or custody?

☐ Yes - If yes, please attach a copy of the sections that apply to health/dental care coverage or custody arrangements ☐ No

Dependents name(s):

Does the court order state who is to maintain insurance coverage for the dependent(s)? ☐ Yes ☐ No ☐ N/A

If yes, who is the responsible party? _____

Does the court order state who has what percentage of custody? ☐ Yes ☐ No ☐ N/A

If yes, who has the highest percentage and what is that percentage? _____

If there is no court order, is the DDKS subscriber's home the primary residence? ☐ Yes ☐ No ☐ N/A

Any additional information you would like to provide:

SECTION 4 - SIGNATURE

I certify that I have read and understand this form and that the information contained in this form is true and completed to the best of my knowledge. I understand I am the enrollee identified or am authorized to act on behalf of the enrollee as a guardian or personal representative. I understand that I may have a copy of this form after I sign it.

DDKS Subscriber Signature **(Required)**: _____

Print Name: _____ Date: _____

Return to Delta Dental of Kansas:
email: COB@deltadentalks.com | mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3392

800.234.3375 | DeltaDentalKS.com

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