



Delta Dental of Minnesota

Delta Dental of Minnesota
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415

Master Dental Contract Application Individually Rated Plans

PART A - Company Information

Client Name (Legal Company Name as it should appear on the contract) City of Columbia Heights

Client Tax Identification/EIN #: 41-6005069 Phone: (763- 706-3600

Physical Address 3989 Central Ave NE Mailing Address _____
(if different than physical address)

City Columbia Heights State MN Zip Code 55421 City _____ State _____ Zip Code _____

Contract Effective Date: 1/1/2027 Renewal Lead Days (Renewal Due Out): 120 days

Coverage Year: ☒ Calendar Year ☐ Other: _____

Participation Requirements: ☐ Employee/Dependent: _____ % / _____ % OR ☒ As Currently Enrolled

Employee Contribution:

100 % Employer Contribution for Employee **Required Information**

100 % Employer Contribution for Dependents **Required Information**

_____ Other Contribution

Does your company currently have a dental plan? ☐ No ☒ Yes (name of carrier) Sunlife

Prior Plan Start Date: 1/1/2024

Eligibility

Total number of eligible* employees 125

*Eligible employees are all employees working 30 hours or more per week

Eligibility probationary period for new employees:

First of the month following _____ Other Date of Hire

Return to work guidelines (Rehire Rule): _____ days Other Rehire Date

Status change (i.e. part time to full time) _____ days Other Date of Status Change

Dependent Eligibility Age Limit: ☒ 26 ☐ Other _____

When does dependent coverage end? ☒ End of Month ☐ Other _____

When does employee coverage end? ☒ Term at End of Month ☐ Other _____

Domestic Partner Covered: ☒ Yes ☐ No

Coordination of Benefits (COB): ☒ Standard ☐ Non-Duplication (i.e. Non-Standard)

Open Enrollment: ☒ Annual/All ☐ Other _____ ☐ Open Enrollment Dates 11/2-11/13

How are we receiving eligibility? ☐ Enrollment Forms ☐ One-time load spreadsheet ☒ Electronic

Date Enrollment will be provided to Delta Dental End of November

Account Structure / Subclient Information

Client Number (assigned by Delta Dental)	Subclient Number	Subclient Name
104308	0001	Active
104308	9271	Cobra/Retiree

Note: If a subclient has an address or contact that is different than the client, please provide that information below:

Materials (ID Cards)

ID Card Required ☒ Yes

Mail to ☐ Client ☒ Individual

Print Client/Subclient Name: ☒ Client ☐ Subclient ☐ Alternate Name _____

Client Contact Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name Ellie Last Name Cortes Greene

Title HR Director

Telephone: 763-703-3608 Ext: _____ Cell: _____

Fax: _____ Email Address: ecortesgreene@columbiaheightsmn.gov

Mailing Address: ☒ Same as Client Physical Location

Street: _____

City _____ State _____ Zip Code _____

To be completed by Delta Dental: Contact Type: ☒ General ☒ Renewal ☐ Billing ☒ Mailing ☒ Materials
☒ Overage Dependent

Additional Client Contact Information (if applicable)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name Andrew Last Name Splinter

Title Director of Finance

Telephone: 763-706-3621 Ext: _____ Cell: _____

Fax: _____ Email Address: asplinter@columbiaheightsmn.gov

Mailing Address: ☒ Same as Client Physical Location

Street _____

City _____ State _____ Zip Code _____

To be completed by Delta Dental: Contact Type: ☐ General ☐ Renewal ☒ Billing ☐ Mailing ☐ Materials
☐ Overage Dependent

Client – Employer Services Portal Registration (ESP)

With the Employer Services Portal (ESP), you can enroll a new member, view and update existing members and view your dental plan benefits. All subscriber listings and ASO claim detail activity reports will only be available on the Employer Services Portal (ESP).

Select a Super User within your company and complete the information below. This Super User will receive access to the portal and is in charge of assigning user permissions within the organization. Delta Dental will e-mail the Super User with registration information and additional instructions.

Client Administrator Name: Ellie Cortes Greene Title: HR Director

Email: ecortesgreene@columbiaheightsmn.gov Phone Number: 763-703-3608

Note: The Super User must be an employee of the client

PART B – Broker of Record - Completion of all fields is required

Broker Producer Name Jenny Van Deinse Agency Name Gallagher Benefit Services

New Broker/Agency? ☐ Yes ☒ No If yes, please complete the Broker Appointment Application online

<http://www.deltadentalmn.org/appointment/#/application/get-started>

NPN#: 18675448 Insurance Producer License ID #: 40558541

Address 3600 American BLVD W Suite 500

City Bloomington State MN Zip Code 55431

Phone 952-356-3852 E-mail Address Jenny_VanDeinse@ajg.com

Broker/Consultant (Primary Contact):

Name Heather Scharnberg Business Title: Senior Client Manager

Business Phone: 612-388-9502 Ext: _____ Email Address: Heather_Scharnberg@ajg.com

Alternate Broker Contact:

Name _____ Business Title: _____

Business Phone: _____ Ext: _____ Email Address: _____

Broker Services Portal Registration (BSP)

With the Broker Services Portal (BSP), the Broker of Record can update and view the client's eligibility and access the client's billing details. Do you currently have a Broker Super User?

☒ Yes If yes, your BSP access will be granted upon new client setup.

☐ No If no, Select a Broker Super User within your company and complete the information below. Delta Dental will e-mail the Broker Super User with registration information and additional instructions.

Broker Super User Name: Ciara Lenzen Title: Broker Super User

Email: ciara_lenzen@ajg.com Phone: (952)356-0727

Broker's Signature: _____ Date: _____

PART C - Billing / Payment Method

Bill Send Type: ☐ Mail ☒ Email Notification Only (Employer Services Portal)

Payment Method: ☒ ACH (Preferred Method) *Please include a completed ACH Authorization Form*

☐ Wire Transfer

PART D - Funding Type

☒ ASO Billing Frequency: Claims: Weekly (Standard) ☒ Monthly ☐

Admin Fee: ☒ Monthly

Admin Fee Sold: Per

Employee Per Month \$ 14.66 Percent of Claims: _____% Other _____

PART E - Instructions

1. Complete Master Dental Contract Application
2. Prepare employee enrollment to be submitted to Delta Dental via enrollment forms, enrollment spreadsheet, or electronic enrollment file.
3. Send this completed application as well as the completed ACH form (if applicable) to your Delta Dental representative or mail to the following address:

Delta Dental of Minnesota Attn: Account Management

500 Washington Avenue South, Suite 2060

Minneapolis, MN 55415

Client Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Delta Dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than twenty-five.

Delta Dental will send a contract upon acceptance of the application and final approval of the Dental Benefit Plan Summary. The contract will indicate the effective date of coverage. The contract is effective only after Delta Dental has accepted this application and has sent a contract to the client. The client administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Delta Dental. Any remittance of payment by Company pursuant to the contract will be considered Company's acceptance of the contract terms in full, regardless of whether Company executes the contract.

SIGNATURE BOX		
Asst Fin Director		
Signature of Authorized Company Official	Title	Date
Andrew Splinter		
Client Administrator/Future Correspondence Contact (please print)		Title
Phone Number	Fax Number	Email Address

**DIRECT DEBIT AUTHORIZATION
VIA ACH (Automatic Withdrawals)****Delta Dental of Minnesota**Client Name: City of Columbia HeightsClient Number: 104308Client Sub-location Number(s): 0001,9271Effective Date: 1/1/2027**Financial Institution Information:**

Bank Name: _____

Bank Address: _____

ABA (Routing) Number: _____

Account Number: _____

Type of Account: _____

I hereby authorize Delta Dental, subsidiaries, and affiliates to initiate automatic withdrawals (ACH) from the account indicated above in accordance with my underlying contract with Delta Dental and Delta Dental's ACH processing policies. I understand that I am responsible for any fees incurred due to the ACH being rejected or returned for any reason by my bank and collection action may be taken.

This authorization will remain in full force and effect until Delta Dental has received written notification from me of its termination in such time as to afford Delta Dental and the Financial Institution a reasonable opportunity to act on it, or until all of my payment obligations under the contract have been satisfied.

Should you have any questions regarding your Direct Debit (ACH) Instructions, please contact the Accounting Department at 1.800.906.4702 or AR@deltadentalmn.org

Mailing address: 500 Washington Avenue So, Suite 2060, Minneapolis, MN 55415

Office hours are Monday through Friday, 8 a.m. to 5 p.m. CST.

Authorized Signature: _____ Date: _____

Printed Name: Andrew Splinter

Phone Number



DESIGNATED CONTACT PERSON(S)

In accordance with §164.504(f)(2)(iii)(B) of the HIPAA Privacy Rule, please designate the person(s) in group health plan administration who is able to receive protected health information (PHI).

Notes: This form must be completed by someone with proper authority within your organization. We require names, not merely job titles, of individuals who may receive PHI.

Please complete a new form whenever there is a change to the Designated Contact Person list.

☒ ADDITION of contact person

☐ CHANGE / DELETION of contact person (please indicate next to name)

Broker Contacts (see below)

☐ Check this box if your group wants to name a BROKER as a Designated Contact Person.

COMPANY NAME: City of Columbia Heights **GROUP #** 104308

Name: Ellie Cortes Greene	Name: Andrew Splinter
Title: HR Director	Title: Finance Director
Address: 3989 Central Ave NE	Address: 3989 Central Ave NE
City, State, Zip: Columbia Heights MN 55421	City, State, Zip: Columbia Heights MN 55421
Phone: 763-703-3608	Phone: 763-706-3621
Fax:	Fax:
Email: ecortesgreene@columbiaheightsmn.gov	Email: asplinter@columbiaheightsmn.gov

Certification of Plan Sponsor of group dental plan who is giving final approval to any additions, deletions or modifications to the information that is currently on file as a result of the submittal of new information included on this form.

Signature	Asst Fin Director
Andrew Splinter	Title
Print Name	Date

E-mail address

DESIGNATED CONTACT FOR BILLING

Name of person to receive weekly Claims Detail Summary Reports: Ellie/Andrew (Listed above)
(Please provide contact information if not provided in chart above).

Please return this form to:

Delta Dental of Minnesota
Attn: Account Management
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415

AUTHORIZATION TO RELEASE CONFIDENTIAL DATA

This AGREEMENT is effective 10/13/2026, between DELTA DENTAL OF MINNESOTA, hereinafter referred to as Delta Dental and City of Columbia Heights, hereinafter referred to as the Client.

WHEREAS, the Client has established a health care plan or plans administered or underwritten by Delta Dental; and

WHEREAS, the Client has entered into an agreement with Authorized Representative(s), Apprize Technology, to perform certain services in connection with the Clients's health care plan; and

WHEREAS, the Client has asked Delta Dental to provide the Authorized Representative with access to Client's records which are in the possession of Delta Dental in order to receive information from Authorized Representative, which means, in part, that the Authorized Representative may have access to confidential information; and

WHEREAS, the access to be provided by Delta Dental involves records and information that must be kept confidential;

NOW, THEREFORE, the Client and Delta Dental agree as follows:

Delta Dental agrees to provide to the Authorized Representative access to records of the Client which are needed to assist in the administration of the health care plan and which may include, but are not limited to, confidential information.

The Client recognizes the sensitive and confidential nature of the data to be provided under this Agreement and agrees:

- To ensure that the data is used solely for the administration of the Client's health care plan;
- To ensure that the transmission, handling, storage, use and eventual elimination of this data will preserve the confidentiality of the data; and
- That information of a proprietary nature provided under this Agreement will not be released to any other party without the express written consent of Delta Dental.

The Client agrees to hold harmless, release and indemnify Delta Dental, its subsidiaries, directors, officers, employees and agents against any and all claims, damages, losses, lawsuits, settlements, judgments, costs, penalties and expenses (including attorney's fees) resulting from or arising, directly, out of or in connection with the release of such data by Delta Dental to the Authorized Representative, at the Client's request, according to this Agreement. The Client also agrees to accept full responsibility for the actions of the Authorized Representative with regard to the data provided to the Authorized Representative pursuant to this Agreement. Client acknowledges that it and its Authorized Representative are responsible for the accuracy of any eligibility information submitted to Delta Dental. The Client agrees and acknowledges that any disputes arising under this Agreement will be governed by the laws of Minnesota, without giving effect to the principles of conflicts of law thereof.

IN WITNESS WHEREOF, the undersigned have hereto affixed their representative signatures.

“DELTA DENTAL”

By: _____

Title: _____

Date: _____

“CLIENT”

By: _____

Asst Fin Director
Title: _____

Date: _____

Certificate Of Completion

Envelope Id: DC1A0A76-9D9D-84D8-8100-4075BEB2E4F2

Status: Sent

Subject: Delta Dental - City of Columbia Heights

Source Envelope:

Document Pages: 9

Signatures: 0

Envelope Originator:

Certificate Pages: 4

Initials: 0

Jenny Smith

AutoNav: Enabled

500 Washington Ave S 2060

Envelopeld Stamping: Enabled

Minneapolis, MN 55415

Time Zone: (UTC-06:00) Central Time (US & Canada)

jasmith@deltadentalmn.org

IP Address: 68.235.70.8

Record Tracking

Status: Original

Holder: Jenny Smith

Location: DocuSign

10/20/2026 12:17:14 PM

jasmith@deltadentalmn.org

Signer Events

Signature

Timestamp

Andrew Splinter

Sent: 10/20/2026 12:20:47 PM

ASplinter@columbiaheightsmn.gov

Viewed: 10/20/2026 1:51:03 PM

Asst Fin Director

Security Level: Email, Account Authentication
(None)

Electronic Record and Signature Disclosure:

Accepted: 10/20/2026 1:51:03 PM

ID: a4b66c38-f246-4b15-a022-48e70e7b5313

Jenny Van Deinse

jenny_vandeinse@ajg.com

Security Level: Email, Account Authentication
(None)

Electronic Record and Signature Disclosure:

Accepted: 11/13/2023 11:02:41 AM

ID: f1a81862-4704-419e-94a7-1a0ea1370220

In Person Signer Events

Signature

Timestamp

Editor Delivery Events

Status

Timestamp

Agent Delivery Events

Status

Timestamp

Intermediary Delivery Events

Status

Timestamp

Certified Delivery Events

Status

Timestamp

Carbon Copy Events

Status

Timestamp

Witness Events

Signature

Timestamp

Notary Events

Signature

Timestamp

Envelope Summary Events

Status

Timestamps

Envelope Sent

Hashed/Encrypted

10/20/2026 12:20:47 PM

Payment Events

Status

Timestamps

Electronic Record and Signature Disclosure

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, Stratacor (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to this Electronic Record and Signature Disclosure (ERSD), please confirm your agreement by selecting the check-box next to 'I agree to use electronic records and signatures' before clicking 'CONTINUE' within the DocuSign system.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after the signing session and, if you elect to create a DocuSign account, you may access the documents for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a \$0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. Further, you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact Stratacor:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by email send messages to: rschaff@deltadentalmn.org

To advise Stratacor of your new email address

To let us know of a change in your email address where we should send notices and disclosures electronically to you, you must send an email message to us at rschaff@deltadentalmn.org and in the body of such request you must state: your previous email address, your new email address. We do not require any other information from you to change your email address.

If you created a DocuSign account, you may update it with your new email address through your account preferences.

To request paper copies from Stratacor

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an email to rschaff@deltadentalmn.org and in the body of such request you must state your email address, full name, mailing address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with Stratacor

To inform us that you no longer wish to receive future notices and disclosures in electronic format you may:

- i. decline to sign a document from within your signing session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
- ii. send us an email to rschaff@deltadentalmn.org and in the body of such request you must state your email, full name, mailing address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

The minimum system requirements for using the DocuSign system may change over time. The current system requirements are found here: <https://support.docusign.com/guides/signer-guide-signing-system-requirements>.

Acknowledging your access and consent to receive and sign documents electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please confirm that you have read this ERSD, and (i) that you are able to print on paper or electronically save this ERSD for your future reference and access; or (ii) that you are able to email this ERSD to an email address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format as described herein, then select the check-box next to 'I agree to use electronic records and signatures' before clicking 'CONTINUE' within the DocuSign system.

By selecting the check-box next to 'I agree to use electronic records and signatures', you confirm that:

- You can access and read this Electronic Record and Signature Disclosure; and
- You can print on paper this Electronic Record and Signature Disclosure, or save or send this Electronic Record and Disclosure to a location where you can print it, for future reference and access; and
- Until or unless you notify Stratacor as described above, you consent to receive exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you by Stratacor during the course of your relationship with Stratacor.