



## Employer Application

Group Dental Coverage

Company Name:	Date Created:	
Address:	DBA (if applicable):	
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Primary Contact Name:	E-Mail Address of Contact:	

**EMPLOYER INFORMATION**

Organization Type:  Corporation  Partnership  Sole Proprietor  Other: \_\_\_\_\_

Full Legal Name of Employer:  
(Include names of subsidiaries or affiliated companies)

Are any divisions billed to a different location?  Yes  No  
If yes, please provide contact name and addresses.

Employer Identification Number (Tax ID):

Has your firm ever filed for or is it in the process of filing for bankruptcy?  Yes  No

**DENTAL PLAN PARTICIPATION AND SELECTION**

Dental Plan Name (Code):

Did the group have dental coverage for the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of prior dental carrier:
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**CONTRACT INFORMATION**

Coverage Begins:	Employee Eligibility:	Coverage Ends:	Dependent Age Limits:
<input type="checkbox"/> Date of Hire 1 <sup>st</sup> of the month following: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 6 Months <input type="checkbox"/> Other	<input type="checkbox"/> Min. 30 Hrs/Wk <input type="checkbox"/> Other _____	<input type="checkbox"/> End of month of termination <input type="checkbox"/> Date of termination <input type="checkbox"/> Other _____	<input type="checkbox"/> 19/25 <input type="checkbox"/> Other _____

Total number of employees on payroll:	Total number of full time/eligible employees (EE):
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Number of COBRA participants in total group:	Number of Retirees in total group:
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**Rates and Contributions**

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	EE				
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

**BILLING AND ADMINISTRATIVE CONTACT INFORMATION**

Please provide the information below if different than above for billing purposes and plan administration.

**BILLING CONTACT**

Contact Name:	Contact Title:	
Address:	E-Mail Address:	
City:	State:	Zip Code:
Phone:	Fax:	

**AGENT/BROKER VERIFICATION****BROKER INFORMATION**

Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

**GENERAL AGENT INFORMATION**

Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

**SIGNATURE SECTION**

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of [31] days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage.

I agree that the company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

**It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.**

Authorized Officer's Name:	Title:
Authorized Officer's Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date: