



**DENTAL CARE PLUS, INC.**  
P.O. Box 625749, Sharonville, OH 45241

**EMPLOYER GROUP DENTAL APPLICATION**

**GROUP INFORMATION**

Legal Name of Employer:			
Applicant's Phone Number:		Federal Tax ID No.	
Nature of Business:		SIC Code:	
Billing Address:		City:	State: Zip Code:
Street Address (if different from above):		City:	State: Zip Code:
Name of Subsidiaries, Divisions. Locations or Affiliates to be Covered:			
Name and Title of Employer Plan Administrator/Human Resources Contact:		Phone Number: ( )	Fax Number: ( )
Proposed Effective Date of Insurance:			
Advance payment of \$_____ is submitted herewith to be applied by the Company to premiums for insurance when and if issued.			

**ELIGIBILITY**

Eligible Classes: _____ Minimum Hours Per Week <input type="checkbox"/> All Full Time Employees <input type="checkbox"/> Retirees <input type="checkbox"/> Other _____ Number Eligible _____ Any excluded classes of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details _____	Employee Benefit Waiting Period:  Current Employees: _____ Day Waiting Period  New Employees: _____ Day Waiting Period
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**Effective Date of Coverage / Termination Date of Coverage**

- Option 1**  Effective immediately/terminated on the last day for which premium has been paid.
- Option 2**  Effective the first day of the month coincident with or next following the date the Employee Benefit Waiting Period is completed and application is approved/terminated on the last day for which premium has been paid.

Note: Option 1 always applies to voluntary coverage.

**PRIOR CARRIER INFORMATION**

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

\_\_\_\_\_ Termination Date  
Carrier Name

For Credit for Prior Coverage to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each insured individual and dependents, if insured.

**DENTAL PREMIUM / MONTHLY COST**

**Select one tier structure:**

- Composite rate: \$\_\_\_\_\_
- Two tier rates: Single: \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Three tier rates: Single: \$\_\_\_\_\_ EE& One Dependent: \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Four tier rates: Single \$\_\_\_\_\_ EE&Spouse \$\_\_\_\_\_ EE/Child(ren): \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Five tier rates: Single: \$\_\_\_\_\_ EE&Spouse: \$\_\_\_\_\_ EE& 1 Child: \$\_\_\_\_\_ EE&Children: \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ EE&Spouse \$\_\_\_\_\_ EE& 1 Child \$\_\_\_\_\_ EE&2 or 3 depts \$\_\_\_\_\_ EE&4or more depts \$\_\_\_\_\_

Will the employees be required to contribute toward the cost of the insurance?  Yes  No

If yes, indicate the percentage of the cost of each coverage the employee will pay.

Coverage

EE Dental

Dep Dental

Employee % or Dollar amount

Note: If the employer pays the entire cost for the **employees**, then 100% of the eligible employees **must** apply for coverage.

**DENTAL COVERAGE INFORMATION**

**Employee Plan Option A:** \_\_\_\_\_

	<b>Benefit Waiting Period</b>	<b>Deductible Amount per Person (check one)</b>	<input type="checkbox"/> <b>PPO Coinsurance Percentage</b> In Network/Out of Network
Preventive Care	<u>0 months</u>	<input checked="" type="checkbox"/> <b>Annual</b>	
Diagnostic Care	<u>0 months</u>	<input type="checkbox"/> <b>Lifetime</b>	
Basic Care	<u>0 months</u>	_____	_____
Major Care	<u>0 months</u>	_____	_____
Orthodontics	<u>0 months</u>	_____	_____
Dental Maximum (except ortho)	<b>Calendar Year</b> <input type="checkbox"/> Plan Year <input type="checkbox"/>	Amount \$ _____	
Orthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Calendar Year Limit \$ <u>n/a</u>	Lifetime Maximum \$ _____
Dental PPO	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Network <u>DentaSelect</u>	

**AS THE UNDERSIGNED EMPLOYER:**

**PREMIUM PAYMENT:** I understand and agree that I am responsible for making the proper monthly premium payments. Furthermore, it is understood that a grace period of thirty-one (31) days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the thirty-one (31) day grace period, coverage for all Covered Persons shall lapse as of the premium due date. Any negotiable premium checks received in an envelope postmarked after the thirty-one (31) day grace period will be refunded less any amounts due (if any) from previous months.

**MY ANSWERS ARE TRUE AND CORRECT:** I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my employees. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any questions. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

**MINIMUM EMPLOYEE/DEPENDENT PARTICIPATION REQUIREMENTS:** I also understand that if I am unable to maintain any minimum employee participation under the employer plan, then coverage may cease.

I agree and understand the insurance coverage which is to be placed in force is subject to all of the provisions of the group policy, including, without limitation to the foregoing, the right of the Insurance Company to periodically request and inspect payroll and personnel records which may have a bearing on or be the basis for any insurance coverage requested, placed in force, or maintained.

**WARNING:** Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Writing Agent

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Signature of Other Agent(s)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Type or Print Applicant's Name

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Agent's Phone Number

\_\_\_\_\_  
Agent's Business Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip