

DENTAL PREMIUM / MONTHLY COST

Select one tier structure:

Employee Plan Option A:

- 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 deps \$ _____ EE&4or more deps \$ _____

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: _____

Select One

	Benefit Waiting Period	Deductible Amount per Person (check one) X Annual <input type="checkbox"/> Lifetime	X PPO Coinsurance Percentage In Network / Out of Network	<input type="checkbox"/> Indemnity Coinsurance Percentage
Preventive Care	0 months	no deductible	/	_____
Diagnostic Care	0 months	no deductible	/	_____
Basic Care	0 months	\$ _____	/	_____
Major Care	___ months	\$ _____	/	_____
Orthodontics	___ months	no deductible	/	_____

Office Visit Co-pay: \$ _____

Other Co-pays \$ _____ Applied to: _____

Dental Maximum (except ortho) **Calendar Year X** Plan Year Amount \$ _____

Orthodontics Yes No If Yes, Calendar Year Limit \$ N/A Lifetime Maximum \$ _____

Dental PPO **X** Yes No Network DentaSelect

OPTIONAL COVERAGE INFORMATION

Optional Benefits (additional premium may be required)

Deductible credit/Annual maximum credit (only available on calendar year plans): Yes No

Coverage for Implants (this box needs to be checked and additional premium paid to add this coverage) Yes

Cosmetic Procedures (this box needs to be checked and additional premium paid to add this coverage) Yes

Posterior Composites (this box needs to be checked and additional premium paid to add this coverage) Yes

Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage) Yes

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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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