

SMALL BUSINESS GROUP APPLICATION

EMPLOYER INFORMATION						
Company Name					Group #	
Address			Suite #	City	State	Zip Code
Contact Person				Title	Phone	
GROUP ENROLLMENT CENSUS				EMAIL ADDRESS		EFFECTIVE DATE
Single	Two Party	Family	Total Enrollment			
EMPLOYEE PREMIUM % CONTRIBUTION				GENDER		
Single	Two Party	Family	Total Enrollment	Male	Female	Total
MONTHLY PREMIUM RATES						
Single:\$_____		Two Party:\$_____		Family:\$_____		
PAYMENT OPTIONS						
CHECK						
Check enclosed in the amount of \$_____ payable to Dentcare Delivery Systems, Inc. representing initial month's premium.						
CREDIT CARD - An additional \$5.00 processing fee will be added to any credit card charge.						
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Initial monthly charge <input type="checkbox"/> Recurring monthly charge (check one or both)						
Name on Card_____						
Card Number_____ Exp. Date_____						
DIRECT DEBIT						
<input type="checkbox"/> Direct Debit *Allow 30 days for processing. First payment must be made by check.						
Routing Number				Account Number		
Financial Institution						
Name on Account						
CHECKLIST OF ENCLOSURES						
<input type="checkbox"/> Signed Group Application.			<input type="checkbox"/> Most recent NYS-45 Quarterly Tax Report.			
<input type="checkbox"/> Group Enrollment form(s) for each employee.			<input type="checkbox"/> Initial monthly premium payment by check (enclosed) or credit card.			
<input type="checkbox"/> Copy of Prior Coverage (if applicable).						
BROKER/AGENT APPOINTMENT						
Broker/Agent			Company Name		SSN/Tax ID#	
By signing below, I acknowledge that I have read and agree to the terms and conditions on the reverse side.						
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.						
Signature					Date	

PLAN SELECTION					
<input type="checkbox"/> CapDent	<input type="checkbox"/> CapDent Plus	<input type="checkbox"/> Select	<input type="checkbox"/> Select Plus	<input type="checkbox"/> Omni	<input type="checkbox"/> Comprehensive Voluntary
Minimum Enrollment of 2 Employees	Minimum Enrollment of 3 Employees	Minimum Enrollment of 2 Employees	Minimum Enrollment of 3 Employees	Minimum Enrollment of 2 Employees	<input type="checkbox"/> Low Option <input type="checkbox"/> Medium Option <input type="checkbox"/> High Option <input type="checkbox"/> High Enhanced Option
SUPPLEMENTAL INFORMATION (INTERNAL USE ONLY)					
Age Limits ____ / ____	Age Ends on <input type="checkbox"/> Birthday <input type="checkbox"/> End of Month <input type="checkbox"/> End of Calendar Year			Ortho Age	
Benefits are per: <input type="checkbox"/> Contract Year <input type="checkbox"/> Calendar Year			Assignment of Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Billing Period: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually			Billing Format: <input type="checkbox"/> Paper <input type="checkbox"/> Email <input type="checkbox"/> FTP		
Term of Agreement: <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 36		Days to Renew: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90		Claims Group	
Vision					
<input type="checkbox"/> V0 - No Vision		<input type="checkbox"/> V2 - Comprehensive Funded II		<input type="checkbox"/> V4 - Designer Materials	
<input type="checkbox"/> V1 - Comprehensive Funded I		<input type="checkbox"/> V3 - Affinity Hybrid		<input type="checkbox"/> V5 - Comprehensive Designer <input type="checkbox"/> VV - Embedded	
Major Service Waiting Periods <input type="checkbox"/> None <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months		Dentcare Delivery Systems, Inc. Account Representative			

TERMS AND CONDITIONS

DENTAL PLAN INFORMATION

This plan is underwritten by Dentcare Delivery Systems, Inc. The Group Dental Agreement can be found on the Healthplex, Inc. (Third Party Administrator) website. A hard copy is available upon request. It is understood and agreed that all benefit levels, exclusions and limitations are detailed in the Certificate of Insurance, and the general provisions of this Agreement are detailed in the General Dental Agreement. It is further understood that, upon the applicant signing this application and upon its acceptance by Dentcare Delivery Systems, Inc., the Group Dental Agreement is binding between the applicant and Dentcare Delivery Systems, Inc.

Application, enrollment cards and payment must be received by the 20th of the month for coverage to begin on the first of the following month. The payment can be made by direct debit, credit card (Visa, Discover or MC) or ACH wire.

MINIMUM PARTICIPATION REQUIREMENT

CapDent and Select: The group agrees to maintain a minimum of two (2) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.

CapDent Plus and Select Plus: The group agrees to maintain a minimum of three (3) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.

Comprehensive Voluntary: Groups with ten (10) or more employees may offer multiple options and are not required to select a single option. Groups with less than ten (10) employees must select a single option. Groups with less than three (3) employees may not select the High or High Enhanced Option.

PAYMENT AUTHORIZATION

Should recurring payment of monthly premium be made through the credit or debit card option, the group authorizes Dentcare Delivery Systems, Inc. to charge its corporate credit or debit card automatically each month on a recurring basis for the 12-month period. Should payment be made through direct debit, the group authorizes Dentcare Delivery Systems, Inc. to directly debit the designated bank account each month.

There is an additional monthly premium of \$10.00 for each family member in excess of five (5).

CANCELLATION POLICY

If dental coverage lapses due to non-payment of premium, it is understood that the group's policy will be terminated in accordance with NYS insurance law.

RENEWAL CONDITIONS

The group is aware that this dental plan is an annual policy. Upon renewal, Dentcare Delivery Systems, Inc. reserves the right to change monthly premium rates.

BROKER/AGENT APPOINTMENT

The group confirms that the Broker/Agent named on this application is/are the Broker/Agent of record and will adhere to the Protected Health Information (PHI) and Personally Identifiable Information (PII) guidelines applicable to the group's members.