Underwritten by:

HEALTHPLEX INSURANCE COMPANY

Administered by:

healthplex

Please send completed form to:

Healthplex Insurance Company
Attention: Sales
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
P 800-468-0466 **F** 516-228-9572

ADULT/FAMILY "OFF-EXCHANGE" GROUP APPLICATION

EMPLOYER/GROUP INFORMATION

Company Name				
Address	Suite #	City	State	Zip Code
Contact Person		Title	Phone	
Email Address	Company Website		Effective Date	

BROKER INFORMATION

Broker/Agent Name	State License #
Company Name	

GROUP PREMIUM WORKSHEET

Please note: Region is based on zip code of the employer/group. Dependents under 19 will receive pediatric benefits. Dependents between and including the ages of 19 and 29 will receive adult benefits.

Please choose one (1) region for your employees *(additional region information on reverse side)*

Region(s)	Number of Individual Members	Number of Single Parent/Child(ren)	Number of Families	Total Monthly Premium
☐ Albany	Monthly Premium: $19.25 x ____	(+) $49.57 x ____	(+) $68.82 x ____	= ____
☐ Rochester, Syracuse, and Utica	Monthly Premium: $19.25 x ____	(+) $42.37 x ____	(+) $61.62 x ____	= ____
☐ Buffalo and Mid-Hudson	Monthly Premium: $19.50 x ____	(+) $42.62 x ____	(+) $62.12 x ____	= ____
☐ NYC and Long Island	Monthly Premium: $11.00 x ____	(+) $28.84 x ____	(+) $39.84 x ____	= ____

Payment Options:

☐ Check enclosed in the amount of $_____ payable to Healthplex Insurance Company.

or

☐ Credit/Debit card - initial amount authorized $_____. Authorize Monthly Recurring Payment? ☐ Yes ☐ No

☐ Visa ☐ MasterCard ☐ Discover *(check one)*

Name on Card: _____

Card Number: _____ Exp. Date: _____

CHECKLIST OF ENCLOSURES

- ☐ Signed Group Application
- ☐ Adult/Family GROUP enrollment form(s) for Off-Exchange plan for each employee
- ☐ Enrollment data provided electronically (if applicable)
- ☐ Most recent NYS-45 Quarterly Tax Report
- ☐ Initial monthly premium payment by check (enclosed) or credit card (as provided herewith)

By signing below, I acknowledge that I have read and agree to the terms and conditions on the back of this form.

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Authorized Signature	Title	Date
Group Number	Internal Sales Rep	

Underwritten by:

HEALTHPLEX INSURANCE COMPANY

Administered by:

healthplex

Please send completed form to:

Healthplex Insurance Company
Attention: Sales
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
P 800-468-0466 **F** 516-228-9572

ADULT/FAMILY "OFF-EXCHANGE" GROUP APPLICATION

TERMS & CONDITIONS

Benefits

I understand that the In-Network benefits insured by Healthplex Insurance Company are only available to our Members at participating dental offices and that there are no Out-of-Network benefits. Dependents under 19 will receive pediatric benefits. Dependents between and including the ages of 19 and 29 will receive adult benefits.

Enrollment Period

If the group application and payment are received between the 1st and 15th day of the month, effective date of my employer/group dental coverage will begin on the 1st day of the following month.

If the group application and payment are received between the 16th and last day of the month, effective date of my employer/group dental coverage will begin on the 1st day of the 2nd month.

Credit Card Payment Authorization

By joining this dental plan, I am authorizing Healthplex Insurance Company to bill the stated credit card on page one (1) for premium due. If I select the monthly recurring payment option, I understand the stated credit card will be charged automatically each month on a recurring basis for the term of the policy.

Termination Policy

If dental coverage lapses due to nonpayment of premium, I understand that my employer/group policy will be terminated in accordance with NYS insurance law.

Renewal Conditions

I am aware that this Adult/Family "Off-Exchange" group dental plan is an annual policy. Upon renewal, Healthplex Insurance Company reserves the right to change monthly premium rates.

Mail Completed Form to:

Healthplex Insurance Company
Attention: Sales
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

NEW YORK STATE REGIONS AND COUNTIES

REGION	COUNTIES
Albany	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Buffalo	Allegany, Cattaraugus, Chautaugua, Erie, Genesee, Niagara, Orleans, Wyoming
Mid-Hudson	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
NYC	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Rochester	Livingston, Monroe, Ontario, Seneca, Wayne, Yates
Syracuse	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins
Utica	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence
Long Island	Nassau, Suffolk

NOTICE OF NON-DISCRIMINATION

Healthplex, Inc., complies with Federal civil rights laws. **Healthplex, Inc.** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthplex, Inc. provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Healthplex, Inc. at 1-800-468-9868. For TTY/TDD services, call 1-800-662-1220.

If you believe that **Healthplex, Inc.** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthplex, Inc.** by:

Mail:	333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553-3608
Phone:	1-800-468-9868 (for TTY/TDD services, call 1-800-662-1220)
Fax:	1-516-228-1734
In person:	Same as Mailing Address (above)
Email:	GA@healthplex.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-468-9868; TTY/TDD 1-800-662-1220.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-468-9868 (TTY: 1-800-662-1220).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 1-800-468-9868 (TTY: 1-800-662-1220).	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-468-9868 (1-800-662-1220 رقم هاتف الصم والبكم:).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-468-9868 (TTY: 1-800-662-1220) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-468-9868 (телетайп: 1-800-662-1220).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-468-9868 (TTY: 1-800-662-1220).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-468-9868 (ATS : 1-800-662-1220).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-468-9868 (TTY: 1-800-662-1220).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-468-9868 (TTY: 1-800-662-1220).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-468-9868 (TTY: 1-800-662-1220).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-468-9868 (TTY: 1-800-662-1220).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-468-9868 (TTY: ১-800-662-1220)।	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-468-9868 (TTY: 1-800-662-1220).	Albanian
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-468-9868 (TTY: 1-800-662-1220).	Vietnamese
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-468-9868 (TTY: 1-800-662-1220).	Gujarati
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-468-9868 (TTY: 1-800-662-1220).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-468-9868 (TTY: 1-800-662-1220)۔	Urdu
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-468-9868 (TTY: 1-800-662-1220).	Portuguese
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-468-9868 (TTY: 1-800-662-1220).	Thai
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-468-9868 (TTY:1-800-662-1220) पर कॉल करें।	Hindi
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-468-9868 (TTY: 1-800-662-1220).	German