Plans Underwritten by:
International Healthcare Services, Inc.

Plans Administered by:
HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

Send Completed Form To:
International Healthcare Services, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
P 800-468-0466 • F 516-228-9572
www.healthplex.com

Group Application

Employer Information

Company Name				Group #
Address	Suite #	City	State	Zip Code
Contact Person	Title		Phone	

Group Enrollment Census

Single	Two Party	Family	Total Enrollment

Email Address

Effective Date

Employee Premium % Contribution

Single	Two Party	Family	Total Enrollment

Gender

Male	Female	Total

Monthly Premium Rates

Single:$_____ Two Party:$_____ Family:$_____

Payment Options

Check

Check enclosed in the amount of $_____ payable to International Healthcare Services, Inc. representing initial month's premium.

Credit Card - An additional $5.00 processing fee will be added to any credit card charge.

☐ Visa ☐ MasterCard ☐ Discover → ☐ Initial monthly charge ☐ Recurring monthly charge (check one or both)

Name on Card_____

Card Number_____Exp. Date_____

Direct Debit

☐ 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

☐ Signed Group Application.
☐ Group Enrollment form(s) for each employee.
☐ Most recent NJ-927 Quarterly Tax Report
☐ Initial monthly premium payment by check (enclosed) or credit card.
☐ Enrollment data provided electronically (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

Dental Plan Details

Plan Type

☐ CapDent New Jersey (Minimum Enrollment of 2 Employees)	☐ CapDent Plus New Jersey ☐ Primary ☐ EPO

Supplemental Information (Internal Use Only)

Billing Period: ☐ Monthly ☐ Quarterly ☐ Annually	Billing Format: ☐ Paper ☐ Email ☐ FTP	Claims Group

Vision

☐ V0 - No Vision	☐ V2 - Comprehensive Funded II	☐ V4 - Designer Materials	
☐ V1 - Comprehensive Funded I	☐ V3 - Affinity Hybrid	☐ V5 - Comprehensive Designer	☐ VV - Embedded

International Healthcare Services, Inc. Account Representative	

Terms and Conditions

Dental Plan Information

This plan is underwritten by International Healthcare Services, 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 International Healthcare Services, Inc., the Group Dental Agreement is binding between the applicant and International Healthcare Services, Inc.

Minimum Participation Requirement

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

Payment Authorization

Application, enrollment cards and payment must be received by the 20th of the month for coverage to begin on the first of the month. The payment can be made by debit card, credit card (Visa, Mastercard or Discover) or ACH Wire. Please make all remittances to: ***International Healthcare Services, Inc.***

Should recurring payment of monthly premium be made through the credit or debit card option, the group authorizes International Healthcare Services, 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 International Healthcare Services, Inc. to directly debit the designated bank account each month.

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, International Healthcare Services, 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.

-OVER-