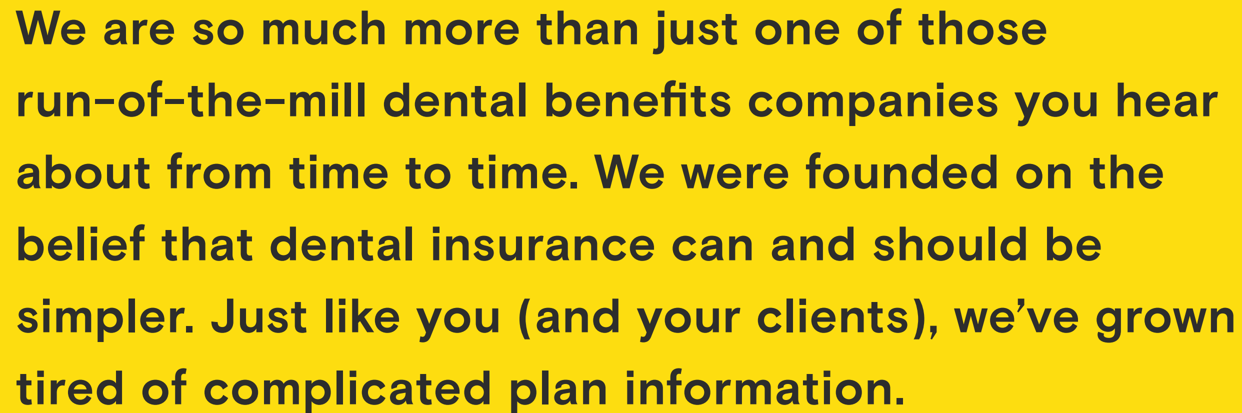
Group Dental Plans

Simplicity that makes you smile.

DentalSelect

Last updated 09/2018



We are so much more than just one of those run-of-the-mill dental benefits companies you hear about from time to time. We were founded on the belief that dental insurance can and should be simpler. Just like you (and your clients), we've grown tired of complicated plan information.

What's wrong with just getting to the point and having all the information you and your clients need in one convenient place? Nothing. And that is exactly what you're looking at now.

Table of Contents

02 Why Dental Select

03 Financial Strength

04 Plan Design Features

06 Nationwide Availability

Dental Select's Dental Plans

07 High Deductible Plan

11 Co-Insurance Dental Plan

15 Co-Pay Dental Plan

19 Discount Vision Plan

23 Customizable Plan Factors

24 Participation Requirements

Dental Select Forms

26 New Group Checklist

27 New Group Application

29 Employee Enrollment Forms

31 Employee Change Forms

33 Group EFT Authorization Form

34 Key Terms

35 FAQs

Why Dental Select?

So what makes Dental Select different? Clearly, it's our attitude. We are a family of over 100 employees who all believe that simplicity is the key to happiness. Every day we each work toward this same goal because we know that you want the same thing for your clients.

We took our first steps to build this foundation in 1989 and we've never sold out. Our little family is currently one of the nation's largest privately-owned dental plan administrators. We have the same transparency and focus we've had from day one without having to report to a bunch of shareholders.

What you'll get from us is a commitment to simplicity that makes you smile. Of course, we have out-of-the-box plans like everyone else, but we can also customize our plans like no other. With streamlined efforts we can set up your groups in less than 10 days, we have plans available in 46 states, and a great team of underwriters that can keep rates competitive and still get your groups the benefits they want. Oh, and we can also help your clients with vision plans supported by EyeMed and its exceptional access to leading national retail outlets as well as a whole lot of private practitioners.

And even though you hear it from every single carrier you work with, we really do have one of the largest nationwide networks with over 200,000 provider access points available. This simply boils down to less disruption and more in-network coverage when you move your groups to Dental Select.

So what's stopping you from getting to know us better? Learn more about us on our website, or contact a Dental Select Sales Executive today.

800-999-9789 | dentalselect.com | quotes@dentalselect.com

Financial Strength

CHUBB®

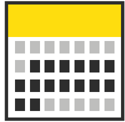
All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

ACE American Insurance Company is rated A++ (Superior) by A.M. Best.

Ratings are an indication of a company's financial strength and ability to meet obligations to its insureds. Chubb NA is the U.S.-based operating division of the Chubb Group of Companies headed by Chubb Ltd. (NYSE: CB) Insurance products and services are provided by Chubb Insurance underwriting companies and not by the parent company itself.

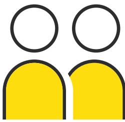
- Chubb is the world's largest publicly traded property and casualty insurer with offices in 54 countries
- A component of S&P 500
- Approximately $160 billion in assets
- Financial strength ratings of AA from Standard & Poor's and A++ from A.M. Best

Flexible Plan Designs for Groups



True Open Enrollment

No late entrant penalties. Employees can enroll annually during open enrollment on a group plan as if it were always the first time.



2 is The Magic Number

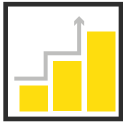
Small group is our big business. We offer contributory and voluntary employer plans for as few as two employees, something you'll never see from those other guys. And if that's not enough sprinkles on your cupcake, groups with as few as 2 employees can qualify for Orthodontics AND our MaxRewards program.

Take It to the Max

We can start any plan with a $1,000 annual maximum. That's easy. But some groups don't want a basic plan. We have options up to $5,000, or go all the way and get a quote for an Unlimited Annual Maximum (based on availability by state). With our plans, the sky is truly the limit!

Convenient Smartphone App

Download Dental Select's smartphone app to find the nearest dentist or for access to dental and vision ID cards. You can even email them right to your dentist.

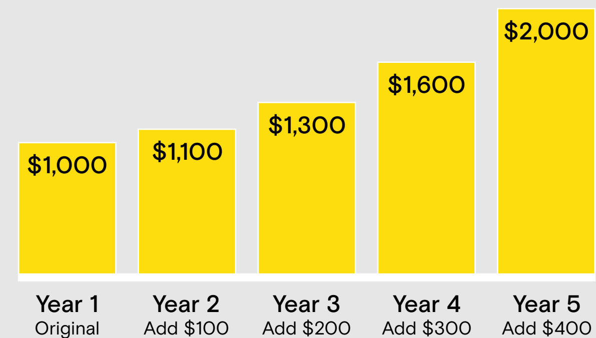


MaxRewards℠ Benefit Program

This program is a broker's best friend. Our MaxRewards program rewards loyal group employees with a graduating annual maximum. Groups can choose their starting annual maximum, and employees will receive an increase every year up to $2,000. It only takes 2 employees on the plan to implement this program.

How it Works
In this example, the employee starts with a $1,000 max on their effective date and benefits increase over 5 years, when they reach the $2,000 maximum.

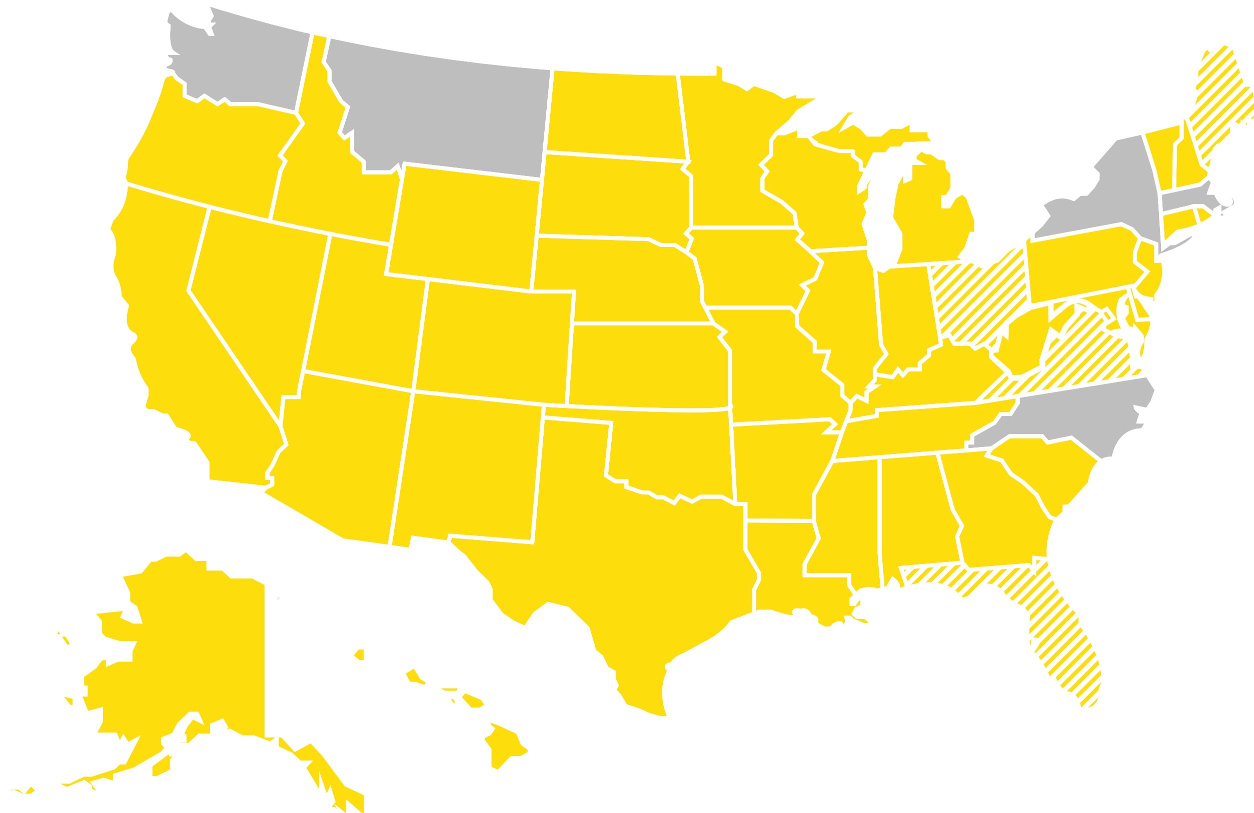
Incremental increases are automatically applied each year, based on consecutive coverage and the original maximum set by the group until the maximum benefit of $2,000 is reached.



Where to Find Us

Dental Select is headquartered in Salt Lake City, Utah. You'll also find us online at dentalselect.com, where you can start the appointment process in our broker section. Once you've sold your first group, we will send you login information so you can manage your block of business.

Nationwide Availability
Group Dental & Vision Coverage



Dental & Vision

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maryland
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Dakota
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Washington DC
West Virginia
Wisconsin
Wyoming

Dental Only

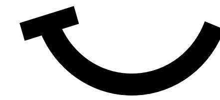
Florida
Maine
Ohio
Virginia

In Progress

Massachusetts
Montana
New York
North Carolina
Washington

Introducing Dental Select’s New

High Deductible Plan



Simple. Straightforward. Affordable.

Currently available only in Texas and Utah.

DentalSelect

Get over the overcomplicated.

Have your clients been asking for simple benefits that don't cost them a fortune? Well, you just found the solution. Dental Select's High Deductible Plan[1] offers low premiums and transparency with our easiest plan design yet. Straightforward, consistent and affordable.

The way dental should be.

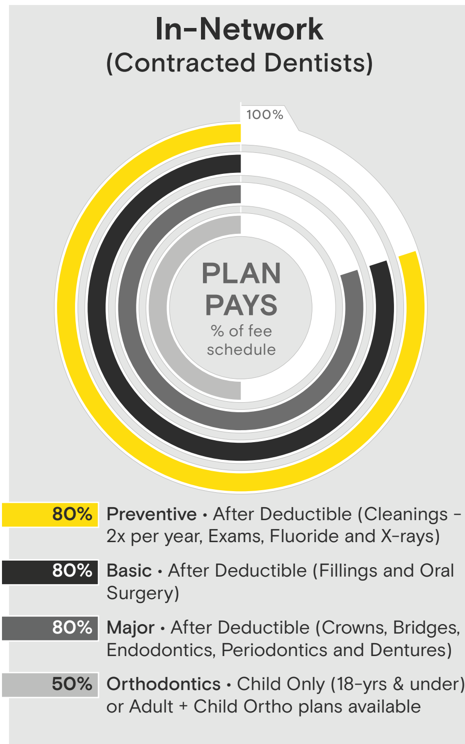
CHUBB®

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

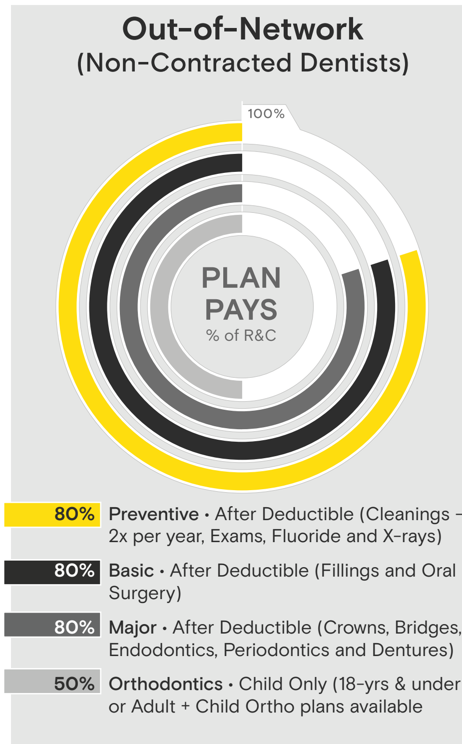
ACE American Insuance Company is rated A++ (Superior) by A.M. Best. Ratings are an indication of the company's financial strength and ability to meet obligations to its insureds.

Important Notice: This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policies issued in the state in which the policy was delivered. Complete details may be found in the policies. The policy is subject to the laws of the state in which it was issued.Chubb NA is the U.S.-based operating division of the Chubb Group of Companies, headed by Chubb, Ltd. (NYSE: CB) Insurance products and services are provided by Chubb Insurance underwriting companies and not by the parent company itself.

High Deductible Plan Summary



80%	**Preventive** • After Deductible (Cleanings – 2x per year, Exams, Fluoride and X-rays)
80%	**Basic** • After Deductible (Fillings and Oral Surgery)
80%	**Major** • After Deductible (Crowns, Bridges, Endodontics, Periodontics and Dentures)
50%	**Orthodontics** • Child Only (18-yrs & under) or Adult + Child Ortho plans available



80%	**Preventive** • After Deductible (Cleanings – 2x per year, Exams, Fluoride and X-rays)
80%	**Basic** • After Deductible (Fillings and Oral Surgery)
80%	**Major** • After Deductible (Crowns, Bridges, Endodontics, Periodontics and Dentures)
50%	**Orthodontics** • Child Only (18-yrs & under) or Adult + Child Ortho plans available

Maximum Benefit

Per Member, per calendar year.
Applies to Preventive, Basic and Major Services.

UNLIMITED
Or Customize.

Deductible

Per Member/per Family, per calendar year.
Applies to Preventive, Basic & Major services.

$200/$600
Or Customize.

Waiting Periods

12-month Waiting Period
applies to Major and Orthodontic Benefits. Or customize.

NOTE: Voluntary groups which have not previously offered a dental program within the last 12 months will include waiting periods unless otherwise requested and approved.

Here's how it works:

- After members satisfy their annual deductible, all covered services for Preventive, Basic & Major will be paid at 80%.[2] Pretty simple, right?
- The deductible applies to Preventive, Basic, and Major Services.
- No waiting periods apply to Preventive or Basic services. A 12-month waiting period applies to Major services, and orthodontia if elected.
- Save an average of 17% on monthly premiums when compared to our standard co-insurance plan.[3]
- Includes our new Unlimited Maximum feature.[4]

- Discount Vision included with every plan.
- Nearly all plan features are customizable. Ask for details.
- Child Only (18-years & under) or Adult+Child orthodontics plans available.

Participation Requirements

Contributory	Voluntary
Minimum of 2 and 75% of all eligible employees	**Groups 2-20:** Minimum of 2 and 25% of eligible employees **Groups 21+:** Minimum of 5 must enroll

1 Dental Select's High Deductible Plan is not a High Deductible Health Plan (HDHP) for purposes of establishing a Health Savings Account (HSA) or eligibility for an HSA.

2 In-network plan payment based on fee schedule, Out-of-network plan payment based on R&C. Waiting periods may apply. Orthodontia services are covered at 50%, if orthodontia is elected. See plan summary for details.

3 The monthly premium for Dental Select's High Deductible dental plan is 17% less, on average, across all tiers, than a standard $50/$150 deductible Dental Select dental plan with comparable benefits at 100/80/50 coinsurance levels.

4 Unlimited Maximum benefits are not available for orthodontia services, which have a $1,000 Lifetime Maximum.

High Deductible Plan Highlights

- Customizable plan features
- More than 200,000 provider access points nationwide
- No waiting periods on Preventive and Basic services
- Preventive, Basic and Major services paid at 80% after deductible[2]
- Insured child only or adult + child orthodontic benefit option
- Unlimited annual maximum included, or customize.
- Save an average of 17% on monthly premiums[3]
- Several deductible options to choose from
- Discount Vision included with every dental plan

To request a quote, contact Dental Select:

800-999-9789 | quotes@dentalselect.com

Texas & Utah network provider:

DentalSelect

DSDCAT2018 PRF.03.9000472 01/18

The Dental Select

Co-Insurance Dental Plan

Standard or Customized Benefits. The Choice is Yours.

DentalSelect

With our Co-Insurance plan, groups can essentially “have it all”. Whether you need quick and easy street rates or lots of customization, this plan can be tailored to your needs. Available customizations include co-insurance percentages, orthodontic and implant options, deductible and maximum settings. Simply tell us your request and we’ll rustle up a quote.

And did we mention this plan can be backed by either our proprietary regional or nationwide dental networks? As our most comprehensive, customizable plan, groups simply can’t go wrong.

CHUBB®

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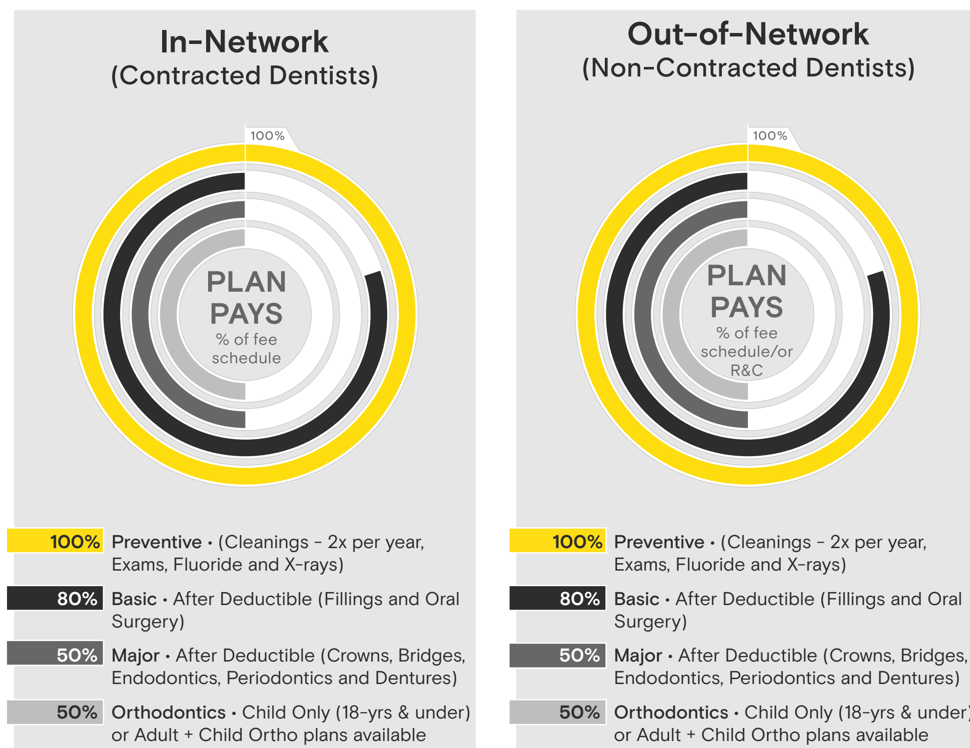
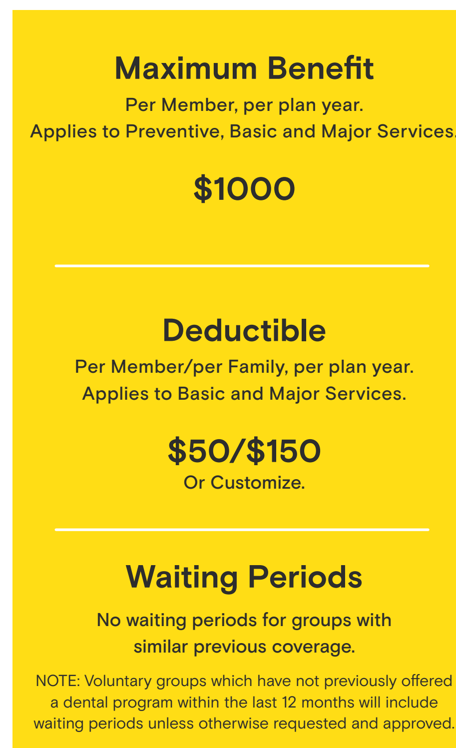
Co-Insurance Plan Summary





- Discount Vision included with every plan.
- Nearly all plan features are customizable. Ask for details.
- MaxRewards℠ Standard Benefit for groups 2+ (Custom maximums are available).

Participation Requirements

Contributory	Voluntary
Minimum of 2 and 75% of all eligible employees	**Groups 2-20:** Minimum of 2 and 25% of eligible employees **Groups 21+:** Minimum of 5 must enroll

Co-Insurance Plan Highlights

- Customizable plan benefits
- Annual Maximum increments up to $5,000 or Unlimited (where available)
- MaxRewards℠ available for groups 2+
- Adult & child Orthodontic benefit options
- Implant benefits available
- Self-funded plans available
- Dual option plans available
- Includes non-insured cosmetic discounts
- Nationwide dentist network access

To request a quote, contact Dental Select:

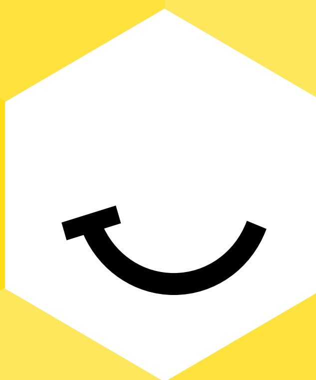
800-999-9789 | quotes@dentalselect.com

National network providers:

DentalSelect

The Dental Select

Co-Pay Dental Plan



A Perfect Combo of Savings and Predictability.

Currently available only in Texas and Utah.

Co-Pay Plans*

Simply put, our Co-Pay plan offers clear-cut care with no surprises. Featuring fixed co-pays, this plan is ideal for groups with fewer dental needs, a younger employee base with smaller families or groups that want to offer an economical dual option. Members like it because they know upfront how much they'll pay at each dental visit. And it comes standard with no annual maximum so they can get as much, or as little, care as they need. Groups like it because this plan generally has lower utilization and lower out-of-pocket costs. And brokers like it because, well, everyone's happy.

* Plan currently only available in Utah and Texas on our Platinum or Gold regional networks.

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Co-Pay Plan Summary

In-Network
(Contracted General Dentists[1])

PLAN PAYS

Preventive: 100%

Basic & Major: Fixed co-pays (based on payment schedule)

AND YOU GET

20% Discount on Orthodondics[2]

Preventive is 100% Paid
(Cleanings - 2x per year, Exams, Fluoride and X-rays)

Basic & Major Have Fixed co-pays
(Fillings and Oral Surgery, Crowns, Bridges, Endodontics, Periodontics and Dentures)

Orthodontics[2] is 20% OFF

Out-of-Network
(Non-Contracted General Dentists[1])

PLAN PAYS

In-network contracted amount Member is responsible for balance.

Applies to Preventive, Basic & Major

See Sample Payment Schedule Online:

dentalselect.com/sample-payment-schedules

Unlimited Maximum Benefit

Per Member, per calendar year.
Applies to Preventive, Basic and Major Services.

20% Discount on In-Network Specialist Care[3]

$0 Deductible for Groups of 6+

($25/$75 for 2-5 enrolled)

Per Member/per Family, per calendar year.
Applies to Basic and Major Services.

Participation Requirements

Minimum of 2 enrolled

No Waiting Periods

- Discount Vision included with every plan.

1 Contracted provider benefit based on a fixed co-pay; Non-contracted provider benefit based on maximum allowable.

2 Discount only - no benefit will be paid.

3 Specialists may include Orthodontists, Pediatric Dentists, Endodontists, Periodontists, Oral Surgeons, and Prosthodontists.

Co-Pay Plan Highlights

- In-network preventive care is covered at 100%
- No annual maximum
- No waiting periods
- Orthodontic discounts
- Teeth bleaching and veneer discounts
- Gold and Platinum network options

To request a quote, contact Dental Select:

800-999-9789 | quotes@dentalselect.com

Texas & Utah network provider:

DentalSelect

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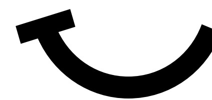
The Dental Select

Discount Vision Plan



Vision Savings That Magically Appear With Every Dental Plan.

DentalSelect

Discount Vision is Included with Every Dental Plan

Is it really magic? No, not really. But we're serious when we say that all dental groups get vision savings for no added cost. And these vision savings are kind of a big deal. You'll get discounts on exams, frames, lenses, contacts and laser eye surgery. Plus members get access to over 75,000 independent practitioners and optical retail providers nationwide, including LensCrafters, Pearle Vision, Target Optical and more.

The EyeMed Networks offer convenient availability of independent providers and leading optical retail providers such as:

LensCrafters

Pearle Vision OPTICAL

GLASSES.COM contactsdirect

Discount Vision Program

Vision Services

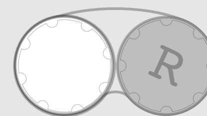
Exam with Dilation as Necessary[1]:	$5 OFF
Standard Contact Lens Fitting:	$10 OFF

Laser Vision Correction*

LASIK or PRK:	15% OFF retail -or- 5% OFF promotion

Cost to Member

Any Frame:	35% OFF Retail
Standard Plastic Lenses:	$50 Single Vision $70 Bifocal $105 Trifocal $135 Progressive
Lens Options:	$15 UV Coating $15 Tint $15 Scratch Resistance $40 Polycarbonate $45 Anti-Reflective 20% OFF Other Add-ons



Cost to Member

Conventional Contact Lenses:	15% OFF retail
Disposable Contact Lenses:	N/A

No Maximums

No Waiting Periods

No Claims to Submit

No Visit Limitations

Dental Select's vision products are provided through EyeMed Vision Care, which offers access to more than 75,000 independent practitioners and optical retail providers at more than 27,000 locations nationwide.

To find a discount network provider near you, visit dentalselect.com or call Customer Care at 800-999-9789.

*15% OFF Retail price of LASIK or PRK or 5% OFF promotional price, in-network providers only. No benefit out-of-network.

1 - Under Contract, ACCESS Vision Providers may charge reasonable & customary rates for a comprehensive exam up to a contracted fee per region.

The EyeMed Discount Vision program is a fee for service discount program, it is not an insured product. This program provides discounts only from a certain network of vision providers. The member is responsible to pay for all services but will receive a discount from vision providers who are contracted on the EyeMed Network.

Health Discount Program Operator: Select Benefits Group, Inc., d/b/a "Dental Select", 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070.

Exclusions and limitations are as follows:

This is not insurance. After initial purchase, replacement contact lenses may be obtained via the Internet and mailed directly to the member. Details are available at www.eyemedvisionare.com.

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6.

1. Discounts are available at participating in-network providers only. Not all In-network Providers offer all discounts; please confirm your provider offers discounts prior to your appointment;
2. Discounts are not insured benefits and do not apply to certain brand name Vision Materials in which the manufacturer imposes a no-cost discount practice;
3. Discounts cannot be combined with any other discount or promotional offer;
4. Discounts do not apply for services provided by other group benefit plans;
5. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
6. Corrective eyewear required by an employer as a condition of employment and safety eyewear;
7. Plano non-prescription lenses and non-prescription sunglasses;
8. Services provided as a result of any Worker's Compensation law; and
9. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.

To request a quote, contact Dental Select:

800-999-9789 | quotes@dentalselect.com

DSDCAT2018 PRF.03.9000428 01/18

Customizable Plan Factors

Now that you've made it this far, we applaud your committment to really understanding everything we have to offer. Below are a variety of plan options that give you the power to satisfy every group's needs. To make it all happen, just **contact your Dental Select sales rep for a custom quote.**

Annual Maximum

We've got it all. Choose the standard $1,000 annual maximum or go all the way up to $5,000 or even Unlimited. Whatever you choose, we'll make it happen.

Deductible

For our Co-Insurance and Co-Pay plans the options are pretty standard. Deductibles range anywhere from $0 to $200. Consult your Sales Executive for plan-specific options.

Orthodontics

It's time to get straightened out! An Orthodontic benefit can be added to any insured plan. We typically include children up to age 18 but sometimes adults like it too. Co-Insurance groups have the option to add a child and adult orthodontic benefit.

Orthodontics Lifetime Maximums

Standard $1,000 lifetime maximum can be customized, and applies to the Orthodontic benefit only.

MaxRewards

Choose your starting maximum from $1,000, $1,250, or $1,500. Employees will receive an increase to their benefit maximum every calendar year they renew until they reach the $2,000 maximum.

Dental Plan Participation Requirements

Eligibility
Eligible employees must be considered full time and work at least 30 hours per week for a contributory plan, and 20 hours for a voluntary plan.

All employees and dependents must enroll within 30 days from the time the employee becomes eligible for their respective employer benefits program as determined by said employer.

Dependent Eligibility
Eligible dependents are covered up to age 26.

Waiting Periods and Take-over Provision (if applicable)
With proof of coverage and effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior coverage must accompany the application in order to reduce waiting periods.

All other services and coverage relating to any other take-over provision will be based on the certificate issued under the Dental Select policy.

Contributory Coverage

Co-Insurance (PPO R&C & PPO MAC)
- A minimum of 2 eligible persons and 75% of all eligible must enroll.
- The employer must contribute 50% of the single premium to qualify.
- Dual option plans require a minimum of 4 total employees to enroll with a minimum of 2 employees on each plan.

Child Orthodontics
- Requires a minimum of 2 enrolled.

Co-Pay
- A minimum of 2 employees is required to enroll.

Groups which have not offered a dental program within the last 12 months will include waiting periods unless otherwise requested and approved.

Voluntary Coverage

Co-Insurance (PPO R&C & PPO MAC)
- 2-20 eligible: 25% of eligible persons must enroll with a minimum of 2.
- 21+ eligible: Requires a minimum of 5 eligible persons to enroll.
- Dual option plans require a minimum of 4 total employees to enroll with a minimum of 2 employees on each plan.

Child Orthodontics
- Requires a minimum of 2 enrolled.

Co-Pay
- A minimum of 2 employees is required to enroll.

Groups which have not offered a dental program within the last 12 months will include waiting periods unless otherwise requested and approved.

Dental Plan Notes

PPO R&C Plans
- CONTRACTED: All payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule and are accepted as payment in full after the required deductible amount, as shown. Members may receive a discount on orthodontic services from contracted orthodontists.
- NON-CONTRACTED: Dental Select will allow up to the Reasonable & Customary amount for dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility.

PPO MAC Plans
- CONTRACTED: All payments made to contracted General Dentists and Specialists are based on the contracted dental fee schedule and are accepted as payment in full after the required deductible amount, as shown. Members may receive a discount on orthodontic services from contracted orthodontists.
- NON-CONTRACTED: Dental Select will allow up to the contracted dental fee schedule amount for dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility.

Co-Pay Plans (Available in Texas and Utah only)
- CONTRACTED: All payments made to contracted General Dentists are based on the contracted dental fee schedule for co-pay plans. Contracted General Dentists accept a combination of fixed co-payments and insurance plan payments as payment in full. Contracted specialists offer members a discount of up to 20% on their usual billed charges. There is no plan payment to contracted specialists.
- NON-CONTRACTED: All payments made to non-contracted General Dentists are based on the contracted dental fee schedule for co-pay plans. The member is responsible for paying the difference between the plan payment and the General Dentist's usual charges. Non-contracted specialists do not offer members a discount and there is no plan payment to non-contracted specialists.

Administration Fee
Fully insured plans include a $2.00 monthly administration fee per subscriber for groups with 2-49 enrolled. The fee maximum is $20.00 per month. No monthly administration fee will be charged for groups with 50 or more enrolled.

Dental Select's

Dental Plan Forms

New Group Checklist

For coverage to be effective on the first day of the month, all required information must be submitted no later than the 15th of that month. For example, Submit by July 15th for a July 1st effective date.

Required New Group Information

Please confirm that the following documents are submitted for seamless service.

Completed Group Plan Application

- ☐ Group information with requested effective date and all signatures
- ☐ Plan design selections
- ☐ Plan rates
- ☐ Agent/Broker information – Include appointment forms if necessary

Completed Employee Enrollment Forms

- ☐ Waivers, when applicable

Payment Options

- ☐ Binder Check – Payable to Dental Select
- ☐ ACH Bankdraft

Family Businesses – Any business owned and operated solely by family members is also required to submit the following:

- ☐ Proof of Establishment from State by which the business is governed – Business License, Corporation paperwork, etc.
- ☐ Proof that those enrolled on the Plan are gainfully employed by said business – Pay stubs, tax statements, payroll statements, etc.

Required Take-Over Benefit Information

Copy of Prior Carrier's

- ☐ Certificate Booklet or Summary of Benefits
- ☐ Most recent billing statement listing employees enrolled

Submittal Information

The first month's premium must accompany your application. Thereafter, Dental Select must receive the premium by the 10th day of each month to the P.O. Box address listed in your Administrative Guide.

Submit all completed and signed original forms to:

Dental Select
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy, Utah 84070

or Fax Toll Free: 888-998-8704.

Group Plan Application

DentalSelect

Group Information

Group Name

SIC Code or Industry | Requested Effective Date

Physical Address

City | State | Zip Code

Phone # | Fax #

Nature of Business

Billing Address

City | State | Zip Code

Billing Contact & Title

Phone # | Email

HR Contact & Title | ☐ Create Portal User Account ☐ Allow Broker Admin Permission

Phone # | Email

Agent/Broker Information

☐ Create Portal User Account

Agent's Name | Agent's Email

Agency Name | Agent's Phone #

Agent's Account Manager Name | Agent ID #

Agent's Signature (Required) | Agent Account Manager's Email

GA (If Applicable) | Date

Design Your Plan

☐ Dental ☐ Vision ☐ Dental + Vision

Select Your Preferred Enrollment

☐ Electronic Enrollment (834 File Format) ☐ Spreadsheet ☐ Paper Forms

Select Your ID Card Delivery ☐ To Group ☐ To Employees

Select Your Dental Plan Funding Type ☐ Contributory ☐ Voluntary

Select Your Dental Plan ☐ High Deductible Plan ☐ Co-Ins PPO R&C ☐ Co-Ins PPO MAC** ☐ Co-Pay† ☐ Discount Program*†

Select Orthodontic Option (If desired) ☐ Add Child Only Ortho ☐ Add Adult + Child Ortho

Select Network(s) ☐ Platinum ☐ Gold †

Select Deductible ☐ $25/$75 ☐ $100/$300 ☐ $50/$150 ☐ Other _____/_____

Select Your Vision Plan Funding Type ☐ Contributory ☐ Voluntary

Select Your Vision Plan ☐ Vis 6 ☐ Vis 12 ☐ Vis 8 ☐ Vis 21 ☐ Other ______________

Select Your AD&D Plan Options ☐ Contributory ☐ Voluntary

Beneficiary Designation Required
Additional form available with Employee enrollment.
Principal Sums range from $10,000 to $250,000.
Refer to plan flyer for specifications.

☐ $10,000 ☐ $150,000 ☐ $20,000 ☐ $200,000 ☐ $50,000 ☐ $250,000 ☐ $100,000

Sold Rates – Based on plan design, complete rates below. First month's premium must accompany application.

Plan:	#1_____ Sold Rates	#2_____ Sold Rates	#3_____ Sold Rates	Vision Sold Rates	AD&D Sold Rates
Single:	________	________	________	________	________
Employee/Spouse or E1D:	________	________	________	________	________
Employee/Child(ren):	________	________	________	________	________
Family:	________	________	________	________	________

Monthly Admin Fee: $__________ ($2.00 per employee, maximum $20.00)

* Discount program is not underwritten by ACE American Insurance Company.
** Where permitted by law. † Currently Available Only in TX and UT.

Please Select Payment Option:

☐ **Monthly Billing Invoice** – Initial premium MUST be submitted as a binder check or EFT payment

☐ **Electronic Funds Transfer** – By enrolling in EFT you understand that future payments will be deducted from designated account monthly. Completed EFT form MUST be included with this application.

General Participation

	Dental	Vision		Dental	Vision		Dental	Vision
# Full Time Employees: (at least 30 hr. per week)	_____	_____	# Employees Enrolling: (at least 30 hr. per week)	_____	_____	# Waiving Due to Other Coverage:	_____	_____
% Employer Contribution for Employees:	____%	____%	% Employer Contribution for Dependents:	____%	____%			

Comparable Dental Plans/Waiting Period Waiver

Does the Group now have a comparable dental plan which has been in force for the past 12 consecutive months? ☐ Yes ☐ No

If yes: Name of Carrier: ____ Length of Coverage: ____________________________

Waiting Periods Waived for Prior Comparable Coverage: ☐ Waiting Periods ☐ Orthodontic

With proof of prior coverage and Member's effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior comparable coverage must accompany the application in order to reduce waiting periods.

The waiting periods for Basic, Major and Orthodontic services may be waived (in part or entirely) only for those Employees and Dependents covered on the Group's prior comparable plan. **To qualify for a waiver, the following documentation must accompany this application:**

- **Prior carrier's Summary of Benefits**
- **Most recent Billing Statement, listing the covered employees eligibility date**

New Hire Waiting Periods

Employees will be eligible to enroll the first of the month following the required days of continuous full-time employment with the group. Present employees who are eligible must enroll on the policy effective date, or within 31 days of group effective date. New employees must enroll within 31 days of the date they become eligible. **(Please complete Employee Category below.)**

Employee Category

How long must a new hire be employed before being offered benefits? Benefits are available the first day of the month following:

☐ Exact Date ☐ Waive at initial enrollment*

☐ Date of Hire ☐ Other: _______________

☐ 30 Days

☐ 60 Days

☐ 90 Days

* For initial group enrollment, all existing employees will be enrolled on effective date.

Is the new hire waiting period different for any class of employees (i.e. hourly/salary/mgmt/etc.)? If yes, please identify below.

Class:	New Hire Waiting Period:
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

Minimum of 2 enrollments per class.

How to Submit Your Information

The first month's premium must accompany your application. Therafter, Dental Select must receive the premium by the first day of each month to the P.O. Box address listed in your Administrative Guide.

Any questions? Call 800-999-9789

1. Complete group plan application. Retain a copy for your files.
2. Have each employee compete and sign an employee enrollment form.

-OR-

3. Submit electronic enrollment (834 file format) (ongoing).
4. Send the original group plan application, completed employee enrollment forms and the first month of premium payable to Dental Select to:

Dental Select
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy, Utah 84070

or Toll Free Fax: 888-998-8704

Take-over Provisions

☐ Maximums & Deductibles

When take-over applies, both the maximum and deductible will be reviewed for take-over together. **To qualify for a take-over, documentation for the total and any amount applied, per member for both maximums and deductibles MUST accompany this application.**

Terms & Conditions

By signing below, company officer or authorized person:

- understands that the In-Network plan providers are not agents, representatives, nor employees of Dental Select.
- represents that all information on this application and any attachment is correct and complete to the best of his/her knowledge and belief.
- understands that no insurance will become effective until approved by the Insurance Company.
- understands that no agent has the authority to modify or waive any conditions of this application or the policy nor to bind the Insurance Company by making any promise of representation.
- agrees to maintain and furnish any records necessary to administer the policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation requirements must be met before the policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.
- understands that the employer is the plan sponsor and plan administrator and that neither Dental Select or ACE American Insurance Company, nor any insurance agent is a plan administrator nor fiduciary, as those terms are defined under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to participating employer's plan of the groups insurance, and the questions regarding the tax or legal effects of the plan are to be resolved by the employer with advice of their own counsel.

The applicant hereby requests insurance for eligible persons based on the above statements and representations, and where applicable, agrees to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the applicant.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Fraud Warning for Texas Applicants:

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE US OR ANY OTHER PERSON, MAKES A REQUEST FOR INSURANCE CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIME.

X ____

Signature - Company Officer or Authorized Person

Printed Name Date

Employee Enrollment Form

DentalSelect

Use the Employee Enrollment Form to collect first time employee and dependent information. For existing member changes, please use the Employee Change Form.

Must Be Completed in Full - PLEASE PRINT

First Name	Last Name	M.I.
Address		
City	State	Zip Code
Phone # ☐ OK to Text	Date of Birth (MM/DD/YYYY)	
Email Address		
SSN	Marital Status ☐ Married ☐ Single	Gender ☐ Male ☐ Female
Effective Date (MM/DD/YYYY)	Date of Hire (MM/DD/YYYY) **(Required)**	
Group Number	Subgroup/Department	
Name of Employer		
Employer's Address		

Authorization of Coverage

☐ Check here to waive if no coverage is desired

☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

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I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

CHUBB®

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies.

Plan/Coverage – Confirm available options with your employer. Select all that apply.

Dental Plan	☐ PPO	☐ High	☐ Low	☐ Co-Pay	☐ High Deductible
Network	☐ Gold	☐ Platinum			
Vision Plan	☐ Vis 6	☐ VIs 8	☐ Vis 12	☐ Vis 21	☐ Other ____________
AD&D	☐ Employee	☐ Employee + Dependants		Amount $____________	

If elected, please also complete a Beneficiary Designation form.

Individuals Covered – List individuals and select plan options for whom you are enrolling

☐ Dental ☐ Vision	Spouse Name (Last, First, M.I.)	
Gender ☐ Male ☐ Female	SSN	Date of Birth
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)	
Gender ☐ Male ☐ Female	SSN	Date of Birth
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)	
Gender ☐ Male ☐ Female	SSN	Date of Birth
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)	
Gender ☐ Male ☐ Female	SSN	Date of Birth
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)	
Gender ☐ Male ☐ Female	SSN	Date of Birth

For additional dependents, attach separate sheet.

☐ I am eligible for enrollment based on a qualifying life event.

Qualifying Event ______________________ Date of Event______________

☐ I am eligible for waiting periods to be waived and have met the necessary requirements.

Waiver Requirements:

- Require CCL (Credible Coverage Letter) within 45 days
- Less than 60 day lapse in coverage from a prior dental plan
- Prior comparable plan summary (submitted within 45 days)
- Orthodontic services may not be eligible (unless prior coverage included Orthodontic services)

Signature | Date

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070
800-999-9789 • Toll Free Fax: 888-998-8704

2018 ENR.01.9000216 8/18

Formulario de Inscripción de Empleado

DentalSelect

Utilice el formulario de inscripción de empleado para obtener información del empleado y personas a cargo nuevos. Para realizar cambios de miembros actuales, utilice el formulario de cambio de empleado.

Se debe completar EN SU TOTALIDAD—POR FAVOR, EXCRIBA CON LETRA DE MOLDE LEGIBLE

Nombre	Apellido	Inicial del 2do nombre
Dirección de Envio		
Ciudad	Estado	Código Postal
Número de Teléfono Residencial ☐ OK para Text	Fecha de Nacimiento (DD/MM/AAAA)	
Email Address		
Número de Seguro Social/Numero de Membresía	Estado Civil ☐ Casado/a ☐ Soltero/a	Sexo ☐ Masculino ☐ Femenino
Fecha de Vigencia (DD/MM/AAAA)	Fecha de Contratación (Obligatorio) (DD/MM/AAAA)	
Número de Grupo	Número de Departmento/Subgrupo	
Nombre Completo del Empleador		
Cirecciöon del Empleador		

Autorización de Cobertura/Cambio

☐ A continuación, marque la opción que corresponda si no desea alguna cobertura.

☐ A continuación, marque la opción que corresponda si desea renunciar a la cobertura, si ya cuenta con una cobertura adicional por medio de otra póliza.

Entiendo que las leyes de privacidad protegerán mi información personal, y la divulgarán únicamente de acuerdo a sus disposiciones. Las únicas personas que tendrán acceso a esta información son los trabajadores de la compañía de seguros que administran mi póliza de seguro o reclamaciones, así como otros terceros autorizados por la compañía de seguros. Además, la información puede darse a conocer a aquellos que tengan una necesidad relacionada con seguros reglamentarios o jurídicos para dicha información. En otras situaciones, le pediremos a usted una autorización por escrito para divulgar su información personal.

ADVERTENCIA: ES UN DELITO PROPORCIONAR, A SABIENDAS, INFORMACIÓN FALSA O FRAUDULENTA A LA COMPAÑÍA DE SEGUROS O CUALQUIER OTRA PERSONA. LAS SANCIONES INCLUYEN ENCARCELAMIENTO Y/O MULTAS. ADEMÁS, UNA COMPAÑÍA DE SEGUROS PUEDE NEGAR CUALQUIER BENEFICIO DE COBERTURA SI EL SOLICITANTE PRESENTA INFORMACIÓN FALSA RELACIONADA ESENCIALMENTE CON UNA RECLAMACIÓN.

Advertencia de fraude para los solicitantes en Texas: ADVERTENCIA: CUALQUIER PERSONA QUE INTENCIONAL Y DELIBERADAMENTE NOS ESTAFE O NOS ENGAÑE, O ESTAFE O ENGAÑE A CUALQUIER OTRA PERSONA, O SOLICITE UN SEGURO CON INFORMACIÓN FALSA, INCOMPLETA O CONFUSA, PUEDE SER CULPABLE DE UN DELITO.

Entiendo y acepto que si mi empleador contribuye al costo de cualquiera de los productos de seguros que he decidido rechazar, no tendré derecho a indemnización alguna por mi falta de participación.

CHUBB®

Todos los planes de seguro son comercializados por Dental Select, una agencia aseguradora y respaldada por ACE American Insurance Company, una aseguradora miembro del Grupo de Compañías Chubb.

Cobertura/plan: confirme las opciones disponibles con su empleador. Seleccione las opciones que correspondan.

Dental Plan	☐ PPO	☐ High	☐ Low	☐ Co-Pay	☐ High Deductible
Network	☐ Gold	☐ Platinum			
Plan Vista	☐ Vis 6	☐ VIs 8	☐ Vis 12	☐ Vis 21	☐ Other ____________
AD&D	☐ Empleado	☐ Empleado + Dependiente			Cantidad $____________
	Complete la información del beneficiario en el Formulario de Designación.				

Personas Cubiertas – Enliste las personas a quienes usted desea inscribir, cambiar y/o terminar.

☐ Dental ☐ Vista	Nombre del Cónyuge (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento

Para dependientes adicionales, incluya una forma por separado.

☐ Soy elegible para inscripcion basado en un evento de calificación

Evento de calificación____________________ Fecha del evento____________

☐ Soy elegible para los periodos de espera, para renunciar y cumplí con todos los requisitos necesarios.

Requisitos para la renuncia

- Se requiere una carta de cobertura creíble (Credible Coverage Letter, CCL) dentro de un período de 45 días.
- Un lapso menor a 60 días de la cobertura de un plan de Dental Select previo.
- Resumen comparable del plan anterior enviado dentro de un período de 45 días.
- Los servicios de ortodoncia no son elegibles.

Firma del Empleador (Obligatorio) Fecha (DD/MM/AAAA)

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070 · 800-999-9789
Toll Free Fax: 888-998-8704

2018 ENR.01.9000216 8/18

Employee Change Form

DentalSelect

Use the Employee Change Form to cancel or modify existing member and dependent plan options. For first time employees, please use the Employee Enrollment Form.

Must be completed in full - PLEASE PRINT. Change form is not valid without signature(s)

Name of Employer	Employer's Address	
Group Number	Subgroup/Dept #	
Subscriber's Name	SSN/Member #	Effective Date (MM/DD/YYYY)

Old Employee Name	New Employee Name	
New Address		
City	State	Zip Code
Phone Number	Email Address	

Plan/Coverage Selection – Confirm available options with your employer. Select all that apply.

Requested Dental Plan	☐ High Deductible Plan† ☐ Discount Program*†	☐ PPO ☐ High	☐ Co-Pay† ☐ Low
Network	☐ Gold ☐ Platinum		
Requested Vision Plan	☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other ____________		
AD&D	☐ AD&D - Amount ____________		

Reason/Status – Required for all requested changes. Notice must be given to Dental Select within 30 days.

☐ **Open Enrollment**

☐ **Rehire**
Date of Layoff: ___/___/___ Date of Rehire: ___/___/___

☐ **Loss/Gain of Coverage** (Employee and/or Dependent)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ **Employee Full Time Status Change** (PT to FT)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ **Other** (Mark One)
Date of Change: ___/___/___ Effective Date: ___/___/___
☐ Marriage ☐ Termination
☐ Divorce ☐ Birth
☐ Leave of Absence ☐ Adoption
☐ Change of Address ☐ Name Change
☐ Death

☐ **Cobra** (Mark One)
Date of Change: ___/___/___ Effective Date: ___/___/___
☐ 18 months - Termination
☐ 36 months - Divorce, Loss of Subscriber, Etc.

Cancel (as Indicated)
Cancel Date: ___/___/___
☐ Entire Policy ☐ Dental ☐ Insured Vision ☐ AD&D ☐ COBRA ☐ Dependent (As indicated herein)

Individuals Covered – List individuals and select plan options.

Action	Plans	Name		
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Spouse Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.)		
		Gender: ☐ Male ☐ Female	SSN	Date of Birth

Authorization of Change (Required for all requested changes. Notice must be given within 30 days.)

Please note that changes may result in premium adjustments.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In the event there is a discrepancy regarding any information contained in this form, documentation will be required.

Employer Signature (Required) ____________ Title ____________ Date Signed (MM/DD/YYYY) ____________

Subscriber Signature ____________ Date Signed (MM/DD/YYYY) ____________

* Discount program is not underwritten by ACE American Insurance Company.
† Currently Available Only in TX and UT.

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070 · 800-999-9789
Toll Free Fax: 888-998-8704

Formulario de Cambio de Empleado

DentalSelect

Utilice el formulario de cambio de empleado para cancelar o para modificar las opciones del plan de un miembro o una persona a cargo. Para empleados nuevos, utilice el formulario de inscripción de empleado.

Se debe completar en su totalidad — EN LETRA DE IMPRENTA El formulario de cambio no es válido si no está firmado.

Nombre Completo del Empleador	Dirección del empleador	
Número de Grupo	Número de Departmento/Subgrupo	
Nombre del Titular del Seguro	Número de Seguro Social/Numero de Membresía	Fecha de Vigencia (DD/MM/AAAA)

Nombre del Empleado Anterior	Nombre del Empleado Nuevo	
Dirección Nueva		
Ciudad	Estado	Código Postal
Número de Teléfono Residencial	Email Address	

Selección de cobertura/plan — Confirme las opciones disponibles con su empleador. Seleccione las opciones que correspondan.

Requested Dental Plan	☐ High Deductible Plan† ☐ PPO ☐ Co-Pay† ☐ Discount Program*† ☐ High ☐ Low
Network	☐ Gold ☐ Platinum
Requested Vision Plan	☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other ___________
AD&D	☐ AD&D - Amount ___________

☐ **Inscripción Abierta**

☐ **Volver a Contratar** Fecha de Despido: ___/___/___
Fecha de reincorporación: ___/___/___

☐ **Pérdida o Recuperación de la Cobertura (Empleado y/o Persona a Cargo)** Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___

☐ **Cambio de Estado a Empleado de Tiempo Completo (Medio Tiempo a Tiempo Completo)**
Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___

☐ **Otro (marque una opción)**
Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___
☐ Matrimonio ☐ Cese
☐ Divorcio ☐ Nacimiento
☐ Licencia sin goce de sueldo ☐ Adopción
☐ Cambio de dirección ☐ Cambio de nombre
☐ Muerte

☐ **COBRA (marque una opción)**
Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___
☐ 18 meses — Cese
☐ 36 meses — Divorcio, pérdida de titular, etc.

Cancelación (según se indica)
Fecha de cancelación: ___/___/___
☐ Póliza Completa ☐ Dental ☐ Seguro de Visión ☐ AD&D ☐ COBRA ☐ Persona a cargo (según se indica a continuación)

Personas Cubiertas—Enliste a las personas y seleccione las opciones del plan a las que afectarán estos cambios.

☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre del Cónyuge (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
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Autorización de cambio (Requerida para todos los cambios solicitados. Se debe notificar en un plazo de 30 días.)

Tenga en cuenta que los cambios pueden provocar ajustes en la prima.

ADVERTENCIA: PROPORCIONAR INFORMACIÓN FALSA O TERGIVERSADA A UN AGENTE ASEGURADOR CON EL PROPÓSITO DE ESTAFAR AL ASEGURADOR O A CUALQUIER OTRA PERSONA SE CONSIDERA UN DELITO. LAS PENAS INCLUYEN PRISIÓN Y/O MULTAS. ADEMÁS, UN ASEGURADOR PUEDE NEGAR LOS BENEFICIOS DEL SEGURO SI EL SOLICITANTE PROPORCIONÓ INFORMACIÓN FALSA ESENCIALMENTE RELACIONADA CON UN RECLAMO.

En caso de que exista una discrepancia con respecto a algún dato que contenga este formulario, se le solicitará documentación.

Firma del Empleador (Obligatorio) ____________ Cargo ____________ Fecha de la firma (MM/DD/YYYY) ____________

Firma del titular ____________ Fecha (DD/MM/AAAA) ____________

* El programa de descuento no está respaldado por ACE American Insurance Company.
† Actualmente, solo está disponible en TX y UT. ‡ AD&D = Muerte Accidental y Pérdida de Miembros

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070 · 800-999-9789
Toll Free Fax: 888-998-8704

DentalSelect

Group Electronic Funds Transfer Authorization

Group Information - Please complete the entire form. Please print clearly.

Group Name	Group #

Bank Withdrawal Authorization: Authorization to honor payments drawn by Dental Select, Salt Lake City, UT

☐ One-time Payment Bank Withdrawal Authorization	☐ Recurring Payment Bank Withdrawal Authorization*
Exact Account Name:	
Bank Name:	Bank Address:
Account Number:	Routing #/ABA #/or other Bank Code(s):
Company Contact Person(s):	

Company Contact Phone #	Company Contact Fax #:	Company Contact Email:

☐ I certify that the information above is true and correct and that as an authorized signer for the above named company, authorization is given to Dental Select to electronically process payment from the designated account. The charge will appear on the monthly statement as Dental Select. This authority is to remain in effect until cancelled by written notification to Dental Select.

Acknowledged and Agreed to:

Authorized Signature

Date Signed (MM/DD/YYYY)

Name (Printed):	Title:

Please fax completed form to 801-290-5099

(For your protection, EFT authorization forms are not accepted by email)

* Recurring payments will be processed within two work days of date of invoice issuance, which is on or around the 25th of each month.

Key Terms

Annual Maximum (Max): A maximum dollar amount that a plan will pay towards costs incurred by an individual during the 12-month benefit period.

Claim Form: A standard form most commonly submitted by the dentist that requests a payment of benefits for services provided. Claim forms are also used when requesting a pre-determination of benefits.

Co-insurance: The member's share of costs for services, usually figured as a percentage of the total charge.

Co-pay: The fixed dollar amount required at the time service is rendered.

Deductible: A portion of dental care expenses that must be paid by an individual before their dental plan pays benefits.

Dependent: A child or person for whom another person such as a parent or relative may claim a personal exemption tax deduction. A dependent is a member but not the subscriber on the plan.

Effective Date: The date insurance coverage starts.

Eligible Dependent: A dependent of an insured person who is eligible for dental coverage.

Eligible Employee: An employee who is eligible for benefit coverage, based on the requirements of their employer's dental plan.

Fee Schedule: A list of set fees that are updated annually, are not contingent upon individual conditions and do not vary within that year. Contracted dentists have agreed to use Dental Select's fee schedules with discounted rates.

Member: Any individual enrolled and covered by a Dental Select plan. Both the subscriber and the dependent are considered members.

Member ID: A unique number assigned to identify an individual subscriber, his/her spouse and any dependents covered by a Dental Select plan.

Open Enrollment: The period of time when eligible employees and their dependents can enroll or make changes to their Dental Select plan.

Reasonable and Customary (a.k.a. R&C or UCR): Dental Select claims payments on the Platinum network for non-contracted dentists are limited to R&C amounts. R&C amounts are determined using a combination of national data and historical submitted claims data from dentists.

Subscriber (a.k.a. employee): The person whose employment makes him or her eligible for group dental benefits. All others enrolled on the plan are dependents.

Waiting Period: The time that must pass before some of your benefits can begin.

FAQs

Who can I call for assistance?
Please contact your Dental Select sales executive or your account representative for assistance. Customer Care is also available for phone inquiries by calling 800-999-9789 Monday through Friday 7:00 a.m. to 6:00 p.m. (Mountain Time).

How do I request materials?
You may complete the request form located at dentalselect.com or contact one of our Customer Care Representatives at 800-999-9789.

What do I need to submit with a new group?
A list of required information is included on the New Group Submittal Checklist (see page 30 or under Forms at dentalselect.com).

How do I request a quote?
Email your request to quotes@dentalselect.com

What do I need to include with a quote request?
Please submit the following information with your quote request, if applicable:

- Current and renewal rates
- Claims history/experience
- Census information
- Number of eligible employees
- Employer contribution

Please also submit the following customization requirements:

- Waiting periods
- Deductibles
- R&C
- Benefit structure
- Maximums
- Voluntary or Contributory
- Commission desired (if not standard)

How soon can I expect to receive my quote?
Dental Select strives to turn quote requests around in 24-hours for groups under 100 lives, and in less than 72-hours for larger groups. Quote request volume is typically higher from September to December and may require additional processing time. Please contact us directly for time-sensitive proposals.

How soon will members get their ID cards?
ID cards will be mailed to either the member or employer, as specified by the group, and will arrive approximately 7 – 10 working days from the time enrollment is completed.

If ID cards are lost or needed sooner, they can also be accessed through the Dental Select mobile app or by logging into the member web portal. For first-time login, users can call Customer Care for their Member ID.

When can members start using their benefits?
After the effective date, new hire or other applicable waiting periods, they may begin using their benefits. If a member is unsure, they can verify eligibility with a Customer Care representative at any time.

Small Group is Our Big Business

We offer contributory and voluntary employer plans for groups as small as two employees. Groups of only two even qualify for Orthodontics and MaxRewards.

We've Got You Covered Nationwide.

- More than 200,000 access points across the country
- Just under 100,000 individual dental providers and specialists

Flexibility You Won't Find Anywhere Else

- Most of our plan options (Maximum Annual Benefit, Deductible, Waiting Periods, etc.) can be customized to your group's individual needs
- Our streamlined group adminstration team is here to help you and your clients!

To request a quote, contact Dental Select:

800-999-9789 | quotes@dentalselect.com

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