Group Plan Application

DentalSelect

Group Information

Business Name		
SIC Code or Industry	Requested Effective Date	
Phone #	Fax #	
Physical Street Address		
City	State	Zip Code
Nature of Business		
Billing Address ☐ Same as Physical Address		
City	State	Zip Code
Billing Contact & Title		
Phone #	Email	
HR Contact & Title	☐ Create Portal User Account ☐ Allow Broker Admin Permission	
Phone #	Email	

Agency/Broker Information

☐ Create Portal User Account

Agency Name	Broker Name
Broker's Email	Broker's Phone
Agent ID #	Broker's Account Manager Name
Broker's Signature (Required)	Broker's Account Manager's Email
GA Agency Name (If Applicable)	GA Representative Name & ID

Design Your Plan ☐ Dental ☐ Vision ☐ Dental + Vision

Select Your Preferred Enrollment

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

Select Your ID Card Delivery ☐ In Bulk to Company ☐ Direct to Employees

Select Your Dental Plan Funding Type ☐ Contributory ☐ Voluntary

Select Your Dental Plan

☐ Coinsurance PPO R&C ☐ Coinsurance PPO MAC*
☐ Copay† ☐ High Deductible Plan

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 _____

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

Plan:	#1_____	#2_____	#3_____	Vision
	Sold Rates	**Sold Rates**	**Sold Rates**	**Sold Rates**
Single:	_____	_____	_____	_____
Employee/Spouse or E1D:	_____	_____	_____	_____
Employee/Child(ren):	_____	_____	_____	_____
Family:	_____	_____	_____	_____
Monthly Admin Fee:	$_____	($2.00 per employee, maximum $20.00)		

Please Select Payment Option:

☐ **Monthly Billing Invoice** - Initial premium MUST be submitted as a binder check or credit card 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.

* Where permitted by law. † Currently Available Only in TX and UT.

General Participation

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

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.

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.**

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

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 Ameritas Life Insurance Corp., 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.

The policy & certificate provide limited benefits. Review your policy & certificate carefully.

X _____

Signature - Company Officer or Authorized Person

Printed Name Date