Dental Care PLUS
The plus is service.

Dental Care Plus Group #_____
(DCP use only)

Underwritten by Dental Care Plus, Inc.
100 Crowne Point Place
Cincinnati, Ohio 45241

APPLICATION FOR MASTER GROUP CONTRACT

The Enrolling Unit/Employer named below hereby makes application to Dental Care Plus, Inc. for a Master Group Contract to be issued in accordance with the specifications of the Application.

Please print clearly or type requested information:

EMPLOYER GROUP INFORMATION

Legal Name of Enrolling Unit/Employer:			
Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:		
Mailing Address (if different from above):	City:	State:	Zip Code:

Legal Status: □ Corporation □ Partnership □ Proprietorship □ Trustee

Other (please specify): _____

Nature of Business or Industry:

Subsidiaries – The following subsidiaries, affiliates or other organizations will be included under this Master Group Contract: _____

ELIGIBILITY

All active, full-time employees, working at least 30 hours per week are eligible:

□ Yes □ No If no, list the classes of employees who are eligible: _____

Total number of full-time, eligible employees: _____

Dependent Eligibility:

□ Standard – 19/25 (student verification rules apply)

□ Other _____

Employee Waiting Period

New employees will be effective:

□ first of the month following date of hire □ date of hire
□ 30 days, first of following month □ 31st day of employment
□ 60 days, first of following month □ 61st day of employment
□ 90 days, first of following month □ 91st day of employment

□ Other (please specify): _____

CONTRACT CHARGES / RATES

All Contract Charges ("Rates") shall be paid by the Enrolling Unit/Employer to Dental Care Plus, Inc. at its Home Office on or before each due date. The first Contract Charge is due on _________________ and subsequent Contract Charges are payable monthly.

Select one tier structure:

□ Composite Rate: **$**_____

□ Two tier Rates: Single: **$**\_\_\_\_\_ Family: **$**_____

□ Three tier Rates: Single: **$**\_\_\_\_\_ EE& One Dependent: **$**_____ Family: **$**_____

□ Four tier Rates: Single: **$**\_\_\_\_\_ EE& Spouse **$**_____ EE& Child(ren): **$**\_\_\_\_\_ Family: **$**_____

Will the employees be required to contribute toward the cost of the insurance? □ Yes □ No

If yes, indicate the percentage or dollar amount of the cost of each coverage the employee will pay:

Employee: _____

Dependent: _____

EFFECTIVE & ANNIVERSARY DATES

Effective Date: The Master Group Contract will be delivered and governed by the laws of the state where the Contract was issued and shall take effect on _____ but only if this application is accepted in writing by Dental Care Plus, Inc. at its Home Office.

Renewal / Contract Anniversary Date:

_____

BENEFIT PLAN INFORMATION

Benefit Plan Number: _____

	Annual Individual / Family Deductible Amount	**HMO Coinsurance Percentage**
Preventive Benefits	no deductible	
Basic Benefits	**$ /**	
Major Benefits	**$ /**	
Orthodontic Benefits	no deductible	

Variable Options: Endodontics: □ Basic □ Major

Periodontics: □ Basic □ Major

Implant Coverage (if elected, will be Major Benefit): □ Yes □ No

Preventive Visit Co-pay: **$**_____ (applies to routine exams and cleanings per visit)

Annual Maximum Benefit (except ortho): Amount **$**_____ □ Calendar Year □ Plan Year

Orthodontics: □ Yes □ No If Yes, Lifetime Maximum Benefit **$**_____

Adult Orthodontics (includes Subscriber and Spouse): □ Yes □ No

Child Orthodontics (includes eligible dependent Children under age 19): □ Yes □ No

CONTACT INFORMATION

Please name the **coordinator** of your dental benefit plan:

Name: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Please name the **finance contact** of your dental benefit plan:

Name: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

SIGNATURES

The Enrolling Unit/Employer hereby agrees and understands that the Master Group Contract issued is based on the information provided in this Application, which Enrolling Unit/Employer hereby represents is true and accurate, and that acceptance of the Master Group Contract by the Enrolling Unit/Employer constitutes agreement to all terms and conditions of the Application and the Master Group Contract. The Master Group Contract shall be deemed accepted if it is not returned by the Enrolling Unit/Employer to Dental Care Plus, Inc. by registered mail within ten (10) business days of receipt. A copy of this Agreement shall be attached to and made a part of the Master Group Contract issued to the Enrolling Unit/Employer. **Dental Care Plus, Inc. reserves the right to rescind the Master Group Contract or to take any other action which Dental Care Plus, Inc. deems necessary if the information provided on this Application is false or inaccurate.**

Ohio Fraud Notice – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Kentucky Fraud Notice – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

For the Enrolling Unit/Employer:

By _____

Title _____ Date _____

For Dental Care Plus, Inc.:

By _____

Title _____ Date _____