



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

DentaSelect Group # \_\_\_\_\_  
 (DCP use only)

### APPLICATION FOR MASTER GROUP POLICY

The Enrolling Unit/Employer named below hereby makes application to Dental Care Plus, Inc. for a Master Group Policy 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: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Trustee <input type="checkbox"/> Other (please specify): _____													
Nature of Business or Industry: _____													
Subsidiaries – The following subsidiaries, affiliates or other organizations will be included under this Master Group Policy: _____													
ELIGIBILITY													
All active, full-time employees, working at least 30 hours per week are eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, list the classes of employees who are eligible: _____ Total number of full-time, eligible employees: _____													
<b>Dependent Eligibility:</b> <input type="checkbox"/> Standard – 19/25 (student verification rules apply) <input type="checkbox"/> Other _____													
<b>Employee Waiting Period:</b> New employees will be effective: <table style="width: 100%; margin-left: 20px;"> <tr> <td><input type="checkbox"/> first of the month following date of hire</td> <td><input type="checkbox"/> date of hire</td> </tr> <tr> <td><input type="checkbox"/> 30 days, first of following month</td> <td><input type="checkbox"/> 31<sup>st</sup> day of employment</td> </tr> <tr> <td><input type="checkbox"/> 60 days, first of following month</td> <td><input type="checkbox"/> 61<sup>st</sup> day of employment</td> </tr> <tr> <td><input type="checkbox"/> 90 days, first of following month</td> <td><input type="checkbox"/> 91<sup>st</sup> day of employment</td> </tr> <tr> <td colspan="2" style="text-align: center;"><input type="checkbox"/> Other (please specify): _____</td> </tr> </table>				<input type="checkbox"/> first of the month following date of hire	<input type="checkbox"/> date of hire	<input type="checkbox"/> 30 days, first of following month	<input type="checkbox"/> 31 <sup>st</sup> day of employment	<input type="checkbox"/> 60 days, first of following month	<input type="checkbox"/> 61 <sup>st</sup> day of employment	<input type="checkbox"/> 90 days, first of following month	<input type="checkbox"/> 91 <sup>st</sup> day of employment	<input type="checkbox"/> Other (please specify): _____	
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<input type="checkbox"/> Other (please specify): _____													



## 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 Policy 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 Policy by the Enrolling Unit/Employer constitutes agreement to all terms and conditions of the Application and the Master Group Policy. The Master Group Policy shall be deemed accepted if it is not returned by the Enrolling Unit/Employer to Dental Care Plus 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 Policy issued to the Enrolling Unit/Employer. **Dental Care Plus, Inc. reserves the right to rescind the Master Group Policy 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 \_\_\_\_\_