Application For Master Group Policy

The Dental Care PLUS GROUP

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: ☐ 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 Policy/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

☐ Dependents are eligible to age 19, or to age 25 if a full time student (Not available in Tennessee)

☐ Dependents are eligible to age 26 regardless of financial dependency, residency, student or marital status

☐ Other: _____

Domestic Partner (non married) Coverage ☐ Yes ☐ No

If yes, please select one of the following: ☐ Same gender only ☐ Same & opposite gender

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): _____

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DENTAL PREMIUM RATES

All Premium 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 Premium Rate is due on _____ and subsequent Premium Rates 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 Policy will be delivered and governed by the laws of the state where the Policy 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/Policy Anniversary Date:

_____

BENEFIT PLAN INFORMATION

	Annual Individual/Family Deductible Amount	**DPPO Coinsurance Percentage** In Network/Out of Network
Preventive Benefits	no deductible	_____ / _____
Basic Benefits	$_____ / _____	_____ / _____
Major Benefits	$_____ / _____	_____ / _____
Orthodontic Benefits	no deductible	_____ / _____

Variable Options: Sealants: ☐ Preventive ☐ Basic

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

NETWORK SELECTION

DPPO Network Selection:

☐ DentaSelect Plus Network

Out-of-Network Reimbursement Level ☐ Advantage 900 ☐ Defined 800 ☐ Match

☐ Balanced Value Network

Out-of-Network Reimbursement Level ☐ Match

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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 Application 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.

Indiana Fraud Notice – A person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

Tennessee Fraud Notice – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For the Enrolling Unit/Employer:

By: _____

Title: _____ Date: _____

For Dental Care Plus, Inc.:

By: _____

Title: _____ Date: _____