DENTALSELECT.

Group Plan Application

GROUP INFORMATION

Group Name			Mailing Address		
SIC Code or Industry	Requested Effective Date		City	State	Zip Code
Physical Address			HR Contact & Title		
City	State	Zip Code	Phone #	Email	
Phone #	Fax #		Billing Contact & Title		
Nature of Business			Phone #	Email	

DESIGN YOUR PLAN

Select Preferred Enrollment

☐ Dental Only ☐ Dental & Vision ☐ Vision Only **ID Card Delivery** ☐ To Group ☐ To Employee

☐ Electronic Enrollment (834 File Format) For groups 50+ enrolled ☐ Spreadsheet (Dental Select authorized form only) ☐ Paper Forms

Dental Plan Options - Utah & Texas Only

Funding: ☐ Contributory Plan ☐ Voluntary Plan **Type:** ☐ Classic

Dental Plan: ☐ Discount - Silver Network* ☐ Co-Insurance PPO/MAC** ☐ Co-Pay ☐ Co-Insurance Passive PPO **Network:**** ☐ Gold ☐ Platinum

AD&D Plan Option: ☐ Contributory - Amount $ _____ ☐ 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 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

Dental Plan Options - All Other States

Funding: ☐ Contributory Plan ☐ Voluntary Plan **Network:** Platinum

Dental Plan: ☐ Co-Insurance PPO/MAC ☐ Co-Insurance Passive PPO ☐ Discount

Select a Vision Plan - Applicable States

Funding: ☐ Contributory Plan ☐ Voluntary Plan

Plan: ☐ Vis 6 ☐ Vis 7 ☐ Vis 8 ☐ Vis 12 ☐ Other _____

SOLD RATES – BASED ON PLAN DESIGN, COMPLETE RATES BELOW

	#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 Administration Fee: $_____
($2.00 per employee: maximum $20.00)

First month's premium must be included with application

DESIGN YOUR PLAN - (CONTINUED)

General Participation

	Dental	Vision		Dental	Vision		Dental	Vision
Number of Full Time Employees: (at least 30 hr. per week)	_____	_____	**Number of Employees Enrolling:**	_____	_____	**Number Waiving Due to Other Coverage:**	_____	_____
Employer Contribution Percentage for Employees:	_____%	_____%	**Employer Contribution Percentage for Dependent**	_____%	_____%	**Number of Employees Enrolling**	_____%	_____%

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
- ☐ Date of Hire
- ☐ 30 Days
- ☐ 60 Days
- ☐ 90 Days
- ☐ Waive at initial enrollment only*
- ☐ Other: _____

*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/management/non-management)? If yes, please identify below. **Minimum of 2 per class.**

Class:	**New Hire Waiting Period Days:**

Comparable Dental Plans

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: _____

Waiting Period Waiver

☐ Waiting Periods ☐ Orthodontic

Waiting Periods Waived for Prior Comparable Coverage:

With proof of 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 in their entirety) 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

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, the following documentation must accompany this application:**

- The total and any amount applied, per member for both maximum and deductibles

Terms & Conditions

By signing on the next page, 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 Property and Casualty 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 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.

(Continued on next page)

DENTALSELECT

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Terms & Conditions (continued)

(Continued from previous page)

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 Kentucky Applicants:
WARNING: 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 INSURANCE ACT, WHICH IS A CRIME.

Signature - Company Officer or Authorized Person	Printed Name	Date

AH-38026

How To Submit Your Information

The first month's premium must accompany the application. Thereafter, Dental Select must receive the premium by the first day of each month to the P.O. Box address listed in the administrative guide.

1. Complete group plan application. Retain a copy for your files.
2. Have each employee complete and sign an employee enrollment form.
3. Submit electronic enrollment (834 file format) for groups 50+ employees enrolled (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
5373 South Green Street, 4th Floor
Salt Lake City, UT 84123
Toll Free Fax: 888-998-8704

Any questions? Call 800-999-9789.

Please Select Payment Option:

☐ **Monthly Billing Invoice** – Initial premium MUST be submitted as a Binder Check.

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

Agent / Broker Information

Agent Name	Email		
Agency Name	Agent Phone #		
GA (if applicable)	Agent ID #		
Agent's Account Manager Name	Account Manager Email		
Agent Signature (required)	Date		
Agent Address	City	State	Zip Code