DentalSelect

Group Vision Plans.

Simplicity that makes you smile.

Updated 04/2020

Hindsight isn’t the only thing that should be 20/20.

On our quest to keep benefits outstanding and simple, we are also looking for easy ways for our brokers to enhance their business too. That’s why we offer a variety of uncomplicated vision plans. Vision plans that are effortless, highly valued and an easy way to enhance your client’s benefits package. They are quick to set up, take little administrative time and are painless to manage. So if you aren’t taking advantage of this simple way to expand your clientele, we think you should be.

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Why Dental Select?

So what makes Dental Select different? Clearly, it's our attitude. We are a family of over 100 employees who all believe that simplicity is the key to happiness.

We know your clients will take notice of major retail brands like LensCrafters, Pearle Vision, and Target Optical. Yeah, we've got all those. Plus, with the ability to order glasses and contacts online, your clients will easily see our commitment to service and simplicity. Day in and day out, our Dental Select family works hard to bring uncluttered, personable experiences and preferred benefits.

When we decided to add vision benefits to our product offerings, we sought out a partner with equal commitment to simplicity, great respect for its members, and the ability to provide unparalleled network access. Our partnership with EyeMed satisfies each of these needs and creates an all-in one benefit opportunity for your clients.

Either bundled or as a stand-alone product, we offer quality products that you can trust to be competitively priced and seamlessly implemented. With plans supported by the EyeMed Vision Care network, client groups have access to 98,000+ independent practitioners and retail providers at 25,000+ locations, making it a smooth sailing decision for groups to sign up.

Get to know us a little better by visiting our website or contacting a Dental Select Sales Executive today.

800-999-9789 | dentalselect.com | quotes@dentalselect.com

National Network of Providers

Whether your clients need an eye exam or are looking to order vision correction materials, they can feel confident choosing from more than 98,000 vision providers, nationwide.

EyeMed vision care has tens of thousands of independent providers across the country as well as over 7,000 stores, including top retailers like LensCrafters, Pearle Vision, and Target Optical. Plus, with online purchase options available from glasses.com and ContactsDirect, materials can be conveniently ordered anytime, anywhere using in-network benefits. Not to mention, your clients will be excited to have top brands like RayBan, Dolce & Gabana, Oakley, Prada and Coach included.

Vision Health & Wellness

Additional Available Programs

GLASSES.COM

Gone are the days when members need to leave their home to purchase glasses. With glasses.com, members can virtually try on and order their glasses, all online. That's right. Before they buy, members can use the award-winning try-on app to see glasses on their own face, three-dimensionally. And as if that isn't enough, another great feature is In Home Try On, which lets members try on the frames they love at home before they buy. Glasses.com will ship directly to the member, and includes a selection of frames, lenses and leading designer brands. In short, members get the convenience and ease they are looking for to make the most of their vision benefits.

contactsdirect

Using benefits should be simple, that's why members can order contacts online too. When ordering replacement lenses, members can easily apply their contact lens benefit at ContactsDirect.com. No visiting a store, no phone calls and no forms are needed. The entire process is done online. By visiting ContactsDirect.com, members select lenses from top selling brands and apply in-network benefits instantly. The best part? Lenses will ship to their home as soon as a prescription is verified with 98% of orders shipping the same day.

IndustrialEyes Safety Eyewear

As part of the Luxottica family, EyeMed vision groups can take advantage of the IndustrialEyes Safety Eyewear Program. This is a valuable discount program for members working for industrial businesses that can be used at more than 2,000 Lenscrafters, Sears Optical and participating Pearle locations. Groups can customize this program by selecting what options are available for their particular work environment and deciding which options are covered. Employees can then shop for eyewear by presenting a copy of their group's Industrial Eyes Safety Eyewear form at time of purchase. This unique program is just another way EyeMed vision plans give clients added value.

The industrialEyes Safety Eyewear program is not an insured benefit and is not underwritten by ACE American Insurance Company.

Competitive Plan Features

Declining balance on contact lens materials (May be used on multiple purchases within the same benefit period up to the maximum allowable.)

Contact lenses AND eyeglass lenses available in the same benefit period on Vis 8 and Vis 12 plans

Eyeglass frame benefit available regardless of lens choice

Members also receive a 40% discount off additional complete pairs of prescription eyeglass purchases and 15% off conventional contact lenses once the funded benefit has been used

20% off non-prescription sunglasses and accessories

Financial Strength

CHUBB®

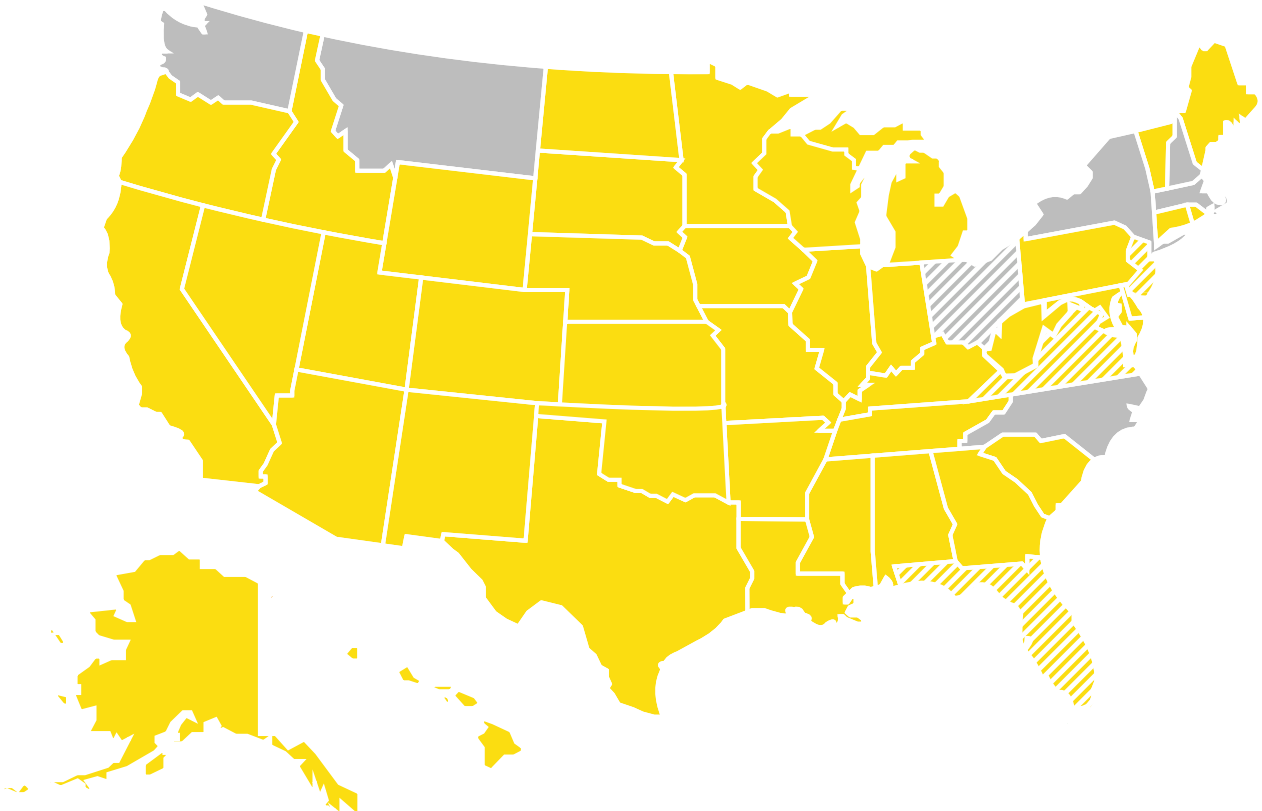
All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies. Chubb NA is the U.S.-based operating division for the Chubb Group of Companies headed by Chubb Ltd. (NYSE: CB) Insurance proucts and servcies are provided by Chubb Insurance Underwriting companies and not by the parent company itself.

ACE American Insurance Company rated A++ (Superior) by A.M. Best.

Ratings are an indication of a company's financial strength and ability to meet obligations to its insureds. Chubb is the world's largest publicly traded property and casualty insurer with:

- Offices in 54 countries
- A component of S&P 500
- Approximately $160 billion in assets

Nationwide Availability
Group Dental & Vision Coverage



Dental & Vision

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Mexico
North Dakota
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Washington DC
West Virginia
Wisconsin
Wyoming

Dental Only

Florida
New Jersey
Virginia

Vision Only

Ohio

In Progress

Massachusetts
Montana
New York
North Carolina
Washington
New Hampshire

Interested in Adding Dental Coverage?

For more than 30 years, Dental Select has consistently offered affordable and customizable dental benefits to businesses of all sizes. All of our dental plans are backed by a provider network with over 360,000 access points nationwide. Plus, you can combine your vision and dental coverage on one invoice and access your plans via our online portal, making managing your company's benefits even easier.

Dental Benefits with Dental Select

- Available with no waiting periods
- Annual maximums up to unlimited (based on avaiability by state)
- Customizable plans designs
- Preventive coverage at up to 100%
- Nationwide network with over 360,000 access points
- Dental implant coverage available
- Orthodontia options available for children and adults
- 24/7 online portal access
- Mobile app available for Apple and Android devices

CHUBB®

All plans of insurance are marketed by Dental Select, an insurance agency, and underwritten by ACE American Insurance Company, a member insurer of the Chubb Group of Companies. Chubb NA is the U.S.-based operating division of the Chubb Group of Companies headed by Chubb Ltd. (NYSE: CB) Insurance products and services are provided by Chubb Insurance underwriting companies and not by the parent company itself.

Online and on the Go

Access Vision Benefits Online

Find a Provider

Members can easily find a vision provider by visiting our website at dentalselect.com. After clicking find a provider, scroll to the vision section to search for vision providers in your area.

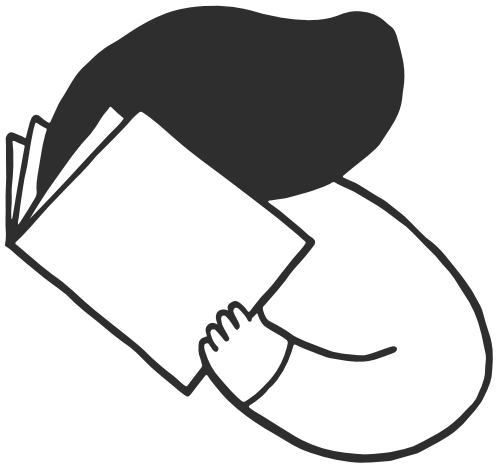
Access the Portal

To access the web portal, members can visit dentalselect.com and click at the top right-hand side of the page where it says “web portal”. A member ID will be required the first time you visit. Here, they can easily view plan documents, review benefits, update personal information and view a claim’s status.

Dental Select's

Group Vision Plans.

Dental Select's vision products are provided through EyeMed Vision Care which offers access to 98,000+ independent practitioners and optical retail providers at more than 25,000 locations nationwide.



Features Include:

- Many locations open 7 days per week, including evenings.
- Laser vision correction discount is 15% off retail price, and 5% off the promotional price.
- Order glasses and contact lenses online using in-network benefits through glasses.com and contactsdirect.com.

DentalSelect

Vis-6 Vision Plan

Our Most Popular Vision Plan

Vision Services

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Exam with Dilation as Necessary	$10			Up to $35
Standard Contact Lens Fitting	Up to $55	Up to $40		N/A
Premium Contact Lens Fitting	10% off			N/A

Vision Correction Discount

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
LASIK or PRK (US Laser Network)	15% off retail -or- 5% off promotion			N/A

Frames

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Any Frame at Provider Location	$0 Copay, $100 Allowance; 20% off balance over $100			Up to $50

Standard Plastic Lenses

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Single Vision	$10			Up to $25
Bifocal	$10			Up to $40
Trifocal	$10			Up to $55
Standard Progressive	$75			Up to $40
Premium Progressive	$75-120 Copay, $120 Allowance; 20% off balance over $120			Up to $40

Lens Options

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
UV Coating	$15			N/A
Tint (solid/gradient)	$15			
Scratch-resistence	$15			
Polycarbonate	$40			
Anit-reflective	$45			
Other add-ons and services	20% off			

Contact Lenses

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Conventional Contact Lenses	$0 Copay, $115 Allowance; 15% off balance over $115			Up to $100
Disposable Contact Lenses	$0 Copay, $115 Allowance; Member pays balance over $115			Up to $100
Medically Necessary Contact Lenses	$0 Copay Paid in full			Up to $200

Benefit Frequencies

Eye Exam: 1x every 12 months
Frames: 1x every 24 months
Glasses Lenses OR Contacts: 1x every 12 months

Members also receive a 40% discount off additional complete pair of prescription eyeglass purchases and 15% off conventional contact lenses once the funded benefit has been used.

Out-of-Network payments may vary in accordance with state requirements.

CHUBB

Vision Plan Notes

Discounts*

- Members may receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Allowances

Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Out-of-Network

Out-of-network payments may vary in accordance with state requirements.

Lasik & PRK

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

Premium Progressive Lenses

Members receive a discount on Premium Progressive lenses at certain locations or when using a contracted vision provider.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL GLASSES.COM contactsdirect

EyeMed vision care has tens of thousands of independent providers across the country as well as over 7,000 stores, including top retailers like LensCrafters, Pearle Vision, and Target Optical. Plus, with online purchase options available from glasses.com and ContactsDirect, materials can be conveniently ordered anytime, anywhere using in-network benefits.

* Discounts on products and services are not insured benefits and not underwritten by ACE American Insurance Company.

DentalSelect

Vis-8 Vision Plan

All the Coverage You Want, Then More

Vision Services

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Exam with Dilation as Necessary	$0			Up to $35
Standard Contact Lens Fitting	Up to $55	Up to $40		N/A
Premium Contact Lens Fitting	10% off			N/A

Vision Correction Discount

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
LASIK or PRK (US Laser Network)	15% off retail -or- 5% off promotion			N/A

Frames

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Any Frame at Provider Location	$0 Copay, $100 Allowance; 20% off balance over $100			Up to $50

Standard Plastic Lenses

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Single Vision	$0			Up to $25
Bifocal	$0			Up to $40
Trifocal	$0			Up to $55
Standard Progressive	$65			Up to $40
Premium Progressive	$65-110 Copay, $120 Allowance; 20% off balance over $120			Up to $40

Lens Options

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
UV Coating	$15			N/A
Tint (solid/gradient)	$15			
Scratch-resistence	$15			
Polycarbonate	$40			
Anit-reflective	$45			
Other add-ons and services	20% off			

Contact Lenses

Network:	Contracted Network: Access (Copay)	Contracted Network: Select (Copay)	Contracted Network: Insight (Copay)	Non-Contracted (Reimbursement)
Conventional Contact Lenses	$0 Copay, $200 Allowance; 15% off balance over $200			Up to $160
Disposable Contact Lenses	$0 Copay, $200 Allowance; Member pays balance over $200			Up to $160
Medically Necessary Contact Lenses	$0 Copay Paid in full			Up to $200

Benefit Frequencies

Eye Exam: 1x every 12 months
Frames: 1x every 12 months
Glasses Lenses AND Contacts: 1x every 12 months

Members also receive a 40% discount off additional complete pair of prescription eyeglass purchases and 15% off conventional contact lenses once the funded benefit has been used.

Out-of-Network payments may vary in accordance with state requirements.

Vision Plan Notes

Discounts*

- Members may receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Allowances

Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Out-of-Network

Out-of-network payments may vary in accordance with state requirements.

Lasik & PRK

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

Premium Progressive Lenses

Members receive a discount on Premium Progressive lenses at certain locations or when using a contracted vision provider.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL GLASSES.COM contactsdirect

EyeMed vision care has tens of thousands of independent providers across the country as well as over 7,000 stores, including top retailers like LensCrafters, Pearle Vision, and Target Optical. Plus, with online purchase options available from glasses.com and ContactsDirect, materials can be conveniently ordered anytime, anywhere using in-network benefits.

* Discounts on products and services are not insured benefits and not underwritten by ACE American Insurance Company.

DentalSelect

Vis-12 Vision Plan

An All Around Good Choice

Vision Services

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Exam with Dilation as Necessary	$10			Up to $35
Standard Contact Lens Fitting	Up to $55	Up to $40		N/A
Premium Contact Lens Fitting	10% off			N/A

Vision Correction Discount

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
LASIK or PRK (US Laser Network)	15% off retail -or- 5% off promotion			N/A

Frames

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Any Frame at Provider Location	$0 Copay, $100 Allowance; 20% off balance over $100			Up to $50

Standard Plastic Lenses

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Single Vision	$10			Up to $25
Bifocal	$10			Up to $40
Trifocal	$10			Up to $55
Standard Progressive	$75			Up to $40
Premium Progressive	$75-120 Copay, $120 Allowance; 20% off balance over $120			Up to $40

Lens Options

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
UV Coating	$15			N/A
Tint (solid/gradient)	$15			
Scratch-resistence	$15			
Polycarbonate	$40			
Anit-reflective	$45			
Other add-ons and services	20% off			

Contact Lenses

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Conventional Contact Lenses	$0 Copay, $120 Allowance; 15% off balance over $120			Up to $100
Disposable Contact Lenses	$0 Copay, $120 Allowance; Member pays balance over $120			Up to $100
Medically Necessary Contact Lenses	$0 Copay Paid in full			Up to $200

Benefit Frequencies

Eye Exam: 1x every 12 months
Frames: 1x every 12 months
Glasses Lenses AND Contacts: 1x every 12 months

Members also receive a 40% discount off additional complete pair of prescription eyeglass purchases and 15% off conventional contact lenses once the funded benefit has been used.

Out-of-Network payments may vary in accordance with state requirements.

Vision Plan Notes

Discounts*

- Members may receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Allowances

Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Out-of-Network

Out-of-network payments may vary in accordance with state requirements.

Lasik & PRK

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

Premium Progressive Lenses

Members receive a discount on Premium Progressive lenses at certain locations or when using a contracted vision provider.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL GLASSES.COM contactsdirect

EyeMed vision care has tens of thousands of independent providers across the country as well as over 7,000 stores, including top retailers like LensCrafters, Pearle Vision, and Target Optical. Plus, with online purchase options available from glasses.com and ContactsDirect, materials can be conveniently ordered anytime, anywhere using in-network benefits.

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DentalSelect

Vis-21 Vision Plan

Plenty of Coverage

Vision Services

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Exam with Dilation as Necessary	$10			Up to $45
Standard Contact Lens Fitting	Up to $40			N/A
Premium Contact Lens Fitting	10% off			N/A

Vision Correction Discount

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
LASIK or PRK (US Laser Network)	15% off retail -or- 5% off promotion			N/A

Frames

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Any Frame at Provider Location	$0 Copay, $130 Allowance; 20% off balance over $130			Up to $45

Standard Plastic Lenses

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Single Vision	$25			Up to $40
Bifocal	$25			Up to $60
Trifocal	$25			Up to $80
Standard Progressive	$25			Up to $60
Premium Progressive	$25-70 Copay, $120 Allowance; 20% off balance over $120			Up to $60

Lens Options

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
UV Coating	$15			N/A
Tint (solid/gradient)	$15			
Scratch-resistence	$15			
Polycarbonate	$40			
Anit-reflective	$45			
Other add-ons and services	20% off			

Contact Lenses

Network:	Contracted Network Access (Copay)	Contracted Network Select (Copay)	Contracted Network Insight (Copay)	Non-Contracted (Reimbursement)
Conventional Contact Lenses	$0 Copay, $150 Allowance; 15% off balance over $150			Up to $150
Disposable Contact Lenses	$0 Copay, $150 Allowance; Member pays balance over $150			Up to $150
Medically Necessary Contact Lenses	$0 Copay Paid in full			Up to $210

Benefit Frequencies

Eye Exam: 1x every 12 months
Frames: 1x every 12 months
Glasses Lenses OR Contacts: 1x every 12 months

Members also receive a 40% discount off additional complete pair of prescription eyeglass purchases and 15% off conventional contact lenses once the funded benefit has been used.

Out-of-Network payments may vary in accordance with state requirements.

Vision Plan Notes

Discounts*

- Members may receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Allowances

Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Out-of-Network

Out-of-network payments may vary in accordance with state requirements.

Lasik & PRK

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

Premium Progressive Lenses

Members receive a discount on Premium Progressive lenses at certain locations or when using a contracted vision provider.*

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Vision Plan Comparison

Plan:	Vis-6				Vis-8			
Vision Services	Access Network	Select Network	Insight Network	Out-of-Network	Access Network	Select Network	Insight Network	Out-of-Network
Exam with Dilation as Necesary	$10			Up to $35	$0			Up to $35
Standard Contact Lens fit & folllow-up	Up to $55	Up to $40		N/A	Up to $55	Up to $40		N/A
Premium Contact Lens fit & follow-up	10% off Retail			N/A	10% off Retail			N/A
Frames								
Any Frame at Provider's Location	$0 Copay, $100 Allowance; 20% off Balance over $100			Up to $50	$0 Copay, $100 Allowance; 20% off Balance over $100			Up to $50
Lenses								
Single Vision	$10			Up to $25	$0			Up to $25
Bifocal	$10			Up to $40	$0			Up to $40
Trifocal	$10			Up to $55	$0			Up to $55
Standard Progressive	$75			Up to $40	$65			Up to $40
Premium Progressive	$75-120 Copay, $120 Allowance; 20% off balance over $120			Up to $40	$65-$110 Copay, $120 Allowance; 20% off Balance over $120			Up to $40
Lens Options								
UV Coating	$15			N/A	$15			N/A
Tint (Solid & Gradient)	$15				$15			
Standard Scratch-Resistance	$15				$15			
Standard Polycarbonate	$40				$40			
Standard Anti-Reflective Coating	$45				$45			
Other Add-ons & Services	20% Discount				20% Discount			
Contact Lens Materials								
Conventional	$0 Copay, $115 allowance; 15% off balance over $115			Up to $100	$0 Copay, $200 allowance; 15% off balance over $200			Up to $160
Disposable	$0 Copay, $115 allowance; member responsible for balance over $115			Up to $100	$0 Copay, $200 allowance; member responsible for balance over $200			Up to $160
Medically Necessary	$0 Copay: Paid-in-Full			Up to $200	$0 Copay: Paid-in-Full			Up to $200
Frequency								
Examination	Once every 12 Months				Once every 12 Months			
Frame	Once every 24 Months				Once every 12 Months			
Lenses	Glasses **OR** Contacts every 12 Months				Glasses **AND** Contacts every 12 Months			
Laser Vision Correction								
Lasik or PRK (US Laser Network)	15% off retail price -or- 5% off promotional price			N/A	15% off retail price -or- 5% off promotional price			N/A

Vision Plan Comparison

Plan:	Vis-12				Vis-21			
Vision Services	Access Network	Select Network	Insight Network	Out-of-Network	Access Network	Select Network	Insight Network	Out-of-Network
Exam with Dilation as Necesary	$10			Up to $35	$10			Up to $45
Standard Contact Lens fit & folllow-up	Up to $55	Up to $40		N/A	Up to $40			N/A
Premium Contact Lens fit & follow-up	10% off Retail			N/A	10% off Retail			N/A
Frames								
Any Frame at Provider's Location	$0 Copay, $100 Allowance; 20% off Balance over $100			Up to $50	$0 Copay, $130 Allowance; 20% off Balance over $130			Up to $45
Lenses								
Single Vision	$10			Up to $25	$25			Up to $40
Bifocal	$10			Up to $40	$25			Up to $60
Trifocal	$10			Up to $55	$25			Up to $80
Standard Progressive	$75			Up to $40	$25			Up to $60
Premium Progressive	$75-120 Copay, $120 Allowance; 20% off Balance over $120			Up to $40	$25-70 Copay, $120 Allowance; 20% off Balance over $120			Up to $60
Lens Options								
UV Coating	$15			N/A	$15			N/A
Tint (Solid & Gradient)	$15				$15			
Standard Scratch-Resistance	$15				$15			
Standard Polycarbonate	$40				$40			
Standard Anti-Reflective Coating	$45				$45			
Other Add-ons & Services	20% Discount				20% Discount			
Contact Lens Materials								
Conventional	$0 Copay, $120 allowance; 15% off balance over $120			Up to $100	$0 Copay, $150 allowance; 15% off balance over $150			Up to $150
Disposable	$0 Copay, $120 allowance; 15% off balance over $120			Up to $100	$0 Copay, $150 allowance; member responsible for balance over $150			Up to $150
Medically Necessary	$0 Copay: Paid-in-Full			Up to $200	$0 Copay: Paid-in-Full			Up to $210
Frequency								
Examination	Once every 12 Months				Once every 12 Months			
Frame	Once every 12 Months				Once every 12 Months			
Lenses	Glasses **AND** Contacts every 12 Months				Glasses **OR** Contacts every 12 Months			
Laser Vision Correction								
Lasik or PRK (US Laser Network)	15% off retail price -or- 5% off promotional price			N/A	15% off retail price -or- 5% off promotional price			N/A

Vision Plan Notes

Discounts*

- Members may receive a 20% discount on items not covered by the plan when using contracted providers.
- This discount may not be combined with any other discounts or promotional offers and does not apply to EyeMed Provider's professional services or contact lenses.
- Retail prices may vary by location.
- Discounts do not apply to benefits provided by other group benefit plans.
- When enrolled on the vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Allowances

Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

Out-of-Network

Out-of-network payments may vary in accordance with state requirements.

Lasik & PRK

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

Premium Progressive Lenses

Members receive a discount on Premium Progressive lenses at certain locations or when using a contracted vision provider.*

* Discounts on products and services are not insured benefits and not underwritten by ACE American Insurance Company.

Vision Plan Participation Requirements

Data & Acceptance

Rates are based on information submitted in the request for quote. Dental Select reserves the right to revise our quote if the data provided was inaccurate or has changed from the date of the quote and effective date.

By accepting the terms of a quote, coverage is subject to the carrier's or ACE American Insurance Company's determination that trade or economic sanctions or regulations do not prohibit us from binding coverage.

Eligibility

Eligible employees are considered full time and work at least 30-hours per week for contributory plans, and 20- hours for voluntary plans.

All employees and dependents must enroll within 30 days from the time the employee becomes eligible for their respective employer benefits program as determined by employer.

Dependent Eligibility

Eligible dependents are covered up to age 26 or age per state law.

Contributory Coverage

The employer must contribute 50% of the single premium to qualify. 60% of eligible employees must enroll on the plan.

Voluntary Coverage

A minimum of 2 employees must be enrolled on the plan.

New Group Checklist

All required information must be postmarked by the 15th of effective month in order for coverage to be effective the first day of that month.

Required New Group Information

Please confirm that the following documents are submitted for seamless service.

Completed Group Plan Application

- ☐ Group information with requested effective date and all signatures
- ☐ Plan design selections
- ☐ Plan rates
- ☐ Agent/Broker information – Include appointment forms if necessary

Completed Employee Enrollment Forms

- ☐ Waivers, when applicable

Payment Options

- ☐ Binder Check – Payable to Dental Select
- ☐ ACH Bankdraft

Family Businesses – Any business owned and operated solely by family members is also required to submit the following:

- ☐ Proof of Establishment from State by which the business is governed – Business License, Corporation paperwork, etc.
- ☐ Proof that those enrolled on the Plan are gainfully employed by said business – Pay stubs, tax statements, payroll statements, etc.

The first month's premium must accompany your application. Thereafter, Dental Select must receive the premium by the 10th day of each month to the P.O. Box address listed in your Administrative Guide.

Submit all completed and signed original forms to:

Dental Select
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy, Utah 84070

or Fax Toll Free: 888-998-8704.

Company Details

Business Name: | Industry: | Requested Effective Date:

Phone #: | Fax #: | # of Benefits-Eligible Employees:

Physical Address

Street Address 1: | Street Address 2: | City:

State: | Zip:

Billing Address

☐ Same as Physical Address

Street Address 1: | Street Address 2: | City:

State: | Zip:

Billing Contact

First Name: | Last Name: | Email:

Phone:

HR Contact

First Name: | Last Name: | Email:

Phone:

Agent #1 Information

Agency Name: _____ Agent Name: _____ Agent Email: _____

Agent Phone #: _____ Agent ID: _____ Agent's Account Manager: _____

Agent #2 Information (if applicable)

Agency Name: _____ Agent Name: _____ Agent Email: _____

Agent Phone #: _____ Agent ID: _____ Agent's Account Manager: _____

GA Information (if applicable)

GA Agency Name: _____ GA Representative Name: _____ GA ID: _____

X _____

Signed by Licensed Resident Agent

Select Your Plan Types With Dental Select

☐ Dental ☐ Vision ☐ AD&D

How Will You Submit Enrollments?	☐ Electronic Enrollment	☐ Spreadsheet	☐ Paper Forms
How Should ID Cards be Delivered?	☐ in Bulk to Company	☐ Direct to Employees	

Dental Plan #1

Dental Plan Funding Type:	☐ Contributory	☐ Voluntary
Choose Your Dental Plan:	☐ PPO R&C	☐ PPO MAC
	☐ Copay*	☐ High Deductible Plan
Select Orthodontic Option (if applicable)	☐ Child Only Ortho	☐ Adult + Child Ortho
Choose the Network:	☐ Platinum	☐ Gold*

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

	Sold Rates
Single:	_____
Employee/Spouse or E1D:	_____
Employee/Child(ren):	_____
Family:	_____

Dental Plan #2

Dental Plan Funding Type:	☐ Contributory	☐ Voluntary
Choose Your Dental Plan:	☐ PPO R&C	☐ PPO MAC
	☐ Copay*	☐ High Deductible Plan
Select Orthodontic Option (if applicable)	☐ Child Only Ortho	☐ Adult + Child Ortho
Choose the Network:	☐ Platinum	☐ Gold*

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

	Sold Rates
Single:	_____
Employee/Spouse or E1D:	_____
Employee/Child(ren):	_____
Family:	_____

Dental Plan #3

Dental Plan Funding Type:	☐ Contributory	☐ Voluntary
Choose Your Dental Plan:	☐ PPO R&C	☐ PPO MAC
	☐ Copay*	☐ High Deductible Plan
Select Orthodontic Option (if applicable)	☐ Child Only Ortho	☐ Adult + Child Ortho
Choose the Network:	☐ Platinum	☐ Gold*

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

	Sold Rates
Single:	_____
Employee/Spouse or E1D:	_____
Employee/Child(ren):	_____
Family:	_____

* Available only in Texas and Utah

An Administrative Fee of $2.00 per employee, up to a maximum of 10 employees will be charged per month.

Vision Plan #1

Vision Plan Funding Type:	☐ Contributory	☐ Voluntary
Choose Your Vision Plan:	☐ Vis 6	☐ Vis 12
	☐ Vis 8	☐ Vis 21
	☐ Other _____	
Choose the Network:	☐ EyeMed Select	
	☐ EyeMed Access*	
	☐ EyeMed Insight	

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

	Sold Rates
Single:	_____
Employee/Spouse or E1D:	_____
Employee/Child(ren):	_____
Family:	_____

Vision Plan #2

Vision Plan Funding Type:	☐ Contributory	☐ Voluntary
Choose Your Vision Plan:	☐ Vis 6	☐ Vis 12
	☐ Vis 8	☐ Vis 21
	☐ Other _____	
Choose the Network:	☐ EyeMed Select	
	☐ EyeMed Access*	
	☐ EyeMed Insight	

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

	Sold Rates
Single:	_____
Employee/Spouse or E1D:	_____
Employee/Child(ren):	_____
Family:	_____

AD&D Plan**

AD&D Plan Funding Type:	☐ Contributory	☐ 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.	☐ $50,000	☐ $200,000
	☐ $100,000	☐ $250,000
	☐ $150,000	

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

	Sold Rates
Single:	_____
Family:	_____

Dental Contribution

Employer Contribution for Employees: _____%

Employer Contribution for Dependents: _____%

Vision Contribution

Employer Contribution for Employees: _____%

Employer Contribution for Dependents: _____%

* Available only in Oklahoma, Texas and Utah

** Available only in Texas and Utah

An Administrative Fee of $2.00 per employee, up to a maximum of 10 employees will be charged per month.

Take-Over Provisions

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.

Are you applying for a takeover of Maximums and Deductibles? ☐ Yes ☐ No

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: ☐ All Waiting Periods ☐ Basic/Major Only ☐ Orthodontics Only

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. 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, please submit the following documentation to your Dental Select Account Manager:

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

Is the new hire waiting period different for any class of employees (i.e. hourly/salary/mgmt/etc.)?
If yes, please identify below. Please note there must be a minimum of 2 enrollments per class.

Class:	New Hire Waiting Period:
_____	_____
_____	_____
_____	_____
_____	_____

* For initial group enrollment, all existing employees will be enrolled on effective date.

Payment Authorization Form

Payment Options:

How do you wish to make your initial payment?

- ☐ We will send a paper check (skip this page)
- ☐ We will make a one-time credit card payment (complete section 1 and sign below)
- ☐ We wish to make the initial and ongoing monthly payments via automatic bank withdrawl (complete section 2 and sign below)

Recurring EFT invoice payments can be set up or canceled in Dental Select's group portal at www.dentalselect.com.

Section 1 Binder/Credit Card Authorization

How do you wish to make your initial binder payment? ☐ Credit card (provide credit card info and sign below) ☐ Paper check (skip to next page)

Please complete the following fields to authorize Dental Select to charge your credit card for your one-time binder payment

Card Type: ☐ Visa ☐ MasterCard

Card Number:

Expiration: ___ / ___

Amount to be Charged to Credit Card:

$

Cardholder Name (First/M.I. Last):

Street Address :

City: State: Zip:

Section 2 Bank Widthrawal Authorization

Bank Name:

Routing Number:

Account Number:

Name of/on the Account:

This transaction shall appear on my statement as Dental Select. This authorization will remain in effect until canceled by me in writing. I certify that the information above is true and correct and that as an authorized signer for the above named company, authorization is given to Dental Select to electronically process payment from the designated account.

X

Authorized Signature

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 ACE American 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 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.

x _____

Signature - Company Officer or Authorized Person

Name (Printed):	Title	Date
_____	_____	_____

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.

AR, LA
FRAUD WARNING: any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA
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 the insured person performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy. After 24 months following the issuance of this policy, we will not deny benefits due to any omissions, misrepresentations or inaccuracies in the application, whether willful or not.

FL
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY
Any person who konwingly 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.

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

NY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH
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.

OK
WARNING: any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR
WARNING: 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 may be guilty of insurance fraud. Penalties may 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.

Employee Enrollment Form

DentalSelect

Use the Employee Enrollment Form to collect first time employee and dependent information. For existing member changes, please use the Employee Change Form.

I am eligible for enrollment based on a qualifying life event.

☐ New Hire ☐ Marriage ☐ Open Enrollment

☐ Divorce/Legal Seperation/Annulment ☐ PT to FT Employement ☐ Loss of Other Coverage

Date of event _____

Plan/Coverage – Confirm available options with your employer. Select all that apply.

Requested Dental Plan ☐ Coay ☐ PPO R&C ☐ High Deductible Plan ☐ PPO MAC	Dual Option (PPO) ☐ High ☐ Low	Network ☐ Gold ☐ Platinum
Requested Vision Plan ☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other _____		
Requested AD&D Plan ☐ AD&D - Amount _____		

Must Be Completed in Full - PLEASE PRINT

First Name	Last Name	M.I.
Address		
City	State	Zip Code
Phone # ☐ OK to Text	Date of Birth (MM/DD/YYYY)	
Email Address		
SSN	Marital Status ☐ Married ☐ Single	Gender ☐ Male ☐ Female
Effective Date (MM/DD/YYYY)	Date of Hire (MM/DD/YYYY) **(Required)**	
Group Number	Subgroup/Department	
Name of Employer		
Employer's Address		

Individuals Covered – List individuals and select plan options for whom you are enrolling

☐ Dental ☐ Vision	Spouse Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	
☐ Dental ☐ Vision	Dependent Name (Last, First, M.I.)		
Gender ☐ Male ☐ Female	SSN	Date of Birth	

For additional dependents, attach separate sheet.

Authorization of Coverage

☐ Check here to waive if no coverage is desired

☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

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: 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.

I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

Signature _____ Date _____

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070
800-999-9789 • Toll Free Fax: 888-998-8704

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Formulario de Inscripción de Empleado

DentalSelect

Utilice el formulario de inscripción de empleado para obtener información del empleado y personas a cargo nuevos. Para realizar cambios de miembros actuales, utilice el formulario de cambio de empleado.

Soy elegible para inscripcion basado en un evento de calificación.

☐ New Hire ☐ Marriage ☐ Open Enrollment
☐ Divorce/Legal Seperation/Annulment ☐ PT to FT Employement ☐ Loss of Other Coverage

Fecha del evento ________________

Cobertura/plan: **confirme las opciones disponibles con su empleador. Seleccione las opciones que correspondan.**

Requested Dental Plan ☐ Coay ☐ PPO R&C ☐ High Deductible Plan ☐ PPO MAC	Dual Option (PPO) ☐ High ☐ Low	Network ☐ Gold ☐ Platinum
Requested Vision Plan	☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other _______________	
Requested AD&D Plan	☐ AD&D - Amount _______________	

Se debe completar EN SU TOTALIDAD—POR FAVOR, EXCRIBA CON LETRA DE MOLDE LEGIBLE

Nombre	Apellido	Inicial del 2do nombre
Dirección de Envio		
Ciudad	Estado	Código Postal
Número de Teléfono Residencial ☐ OK para Text	Fecha de Nacimiento (DD/MM/AAAA)	
Email Address		
Número de Seguro Social/Numero de Membresía	Estado Civil ☐ Casado/a ☐ Soltero/a	Sexo ☐ Masculino ☐ Femenino
Fecha de Vigencia (DD/MM/AAAA)	Fecha de Contratación (Obligatorio) (DD/MM/AAAA)	
Número de Grupo	Número de Departmento/Subgrupo	
Nombre Completo del Empleador		
Cirecciòon del Empleador		

Personas Cubiertas – **Enliste las personas a quienes usted desea inscribir, cambiar y/o terminar.**

☐ Dental ☐ Vista	Nombre del Cónyuge (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Dental ☐ Vista	Nombre del Dependiente (Apellido, Nombre, Inicial del 2do nombre)	
Sexo ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento

Para dependientes adicionales, incluya una forma por separado.

Autorización de Cobertura/Cambio

☐ A continuación, marque la opción que corresponda si no desea alguna cobertura.

☐ A continuación, marque la opción que corresponda si desea renunciar a la cobertura, si ya cuenta con una cobertura adicional por medio de otra póliza.

Entiendo que las leyes de privacidad protegerán mi información personal, y la divulgarán únicamente de acuerdo a sus disposiciones. Las únicas personas que tendrán acceso a esta información son los trabajadores de la compañía de seguros que administran mi póliza de seguro o reclamaciones, así como otros terceros autorizados por la compañía de seguros. Además, la información puede darse a conocer a aquellos que tengan una necesidad relacionada con seguros reglamentarios o jurídicos para dicha información. En otras situaciones, le pediremos a usted una autorización por escrito para divulgar su información personal.

ADVERTENCIA: ES UN DELITO PROPORCIONAR, A SABIENDAS, INFORMACIÓN FALSA O FRAUDULENTA A LA COMPAÑÍA DE SEGUROS O CUALQUIER OTRA PERSONA. LAS SANCIONES INCLUYEN ENCARCELAMIENTO Y/O MULTAS. ADEMÁS, UNA COMPAÑÍA DE SEGUROS PUEDE NEGAR CUALQUIER BENEFICIO DE COBERTURA SI EL SOLICITANTE PRESENTA INFORMACIÓN FALSA RELACIONADA ESENCIALMENTE CON UNA RECLAMACIÓN.

Advertencia de fraude para los solicitantes en Texas: ADVERTENCIA: CUALQUIER PERSONA QUE INTENCIONAL Y DELIBERADAMENTE NOS ESTAFE O NOS ENGAÑE, O ESTAFE O ENGAÑE A CUALQUIER OTRA PERSONA, O SOLICITE UN SEGURO CON INFORMACIÓN FALSA, INCOMPLETA O CONFUSA, PUEDE SER CULPABLE DE UN DELITO.

Entiendo y acepto que si mi empleador contribuye al costo de cualquiera de los productos de seguros que he decidido rechazar, no tendré derecho a indemnización alguna por mi falta de participación.

Firma del Empleador (Obligatorio) ______________________________ Fecha ______________

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070
800-999-9789 • Toll Free Fax: 888-998-8704

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CHUBB®

Employee Change Form

DentalSelect

Use the Employee Change Form to cancel or modify existing member and dependent plan options. For first time employees, please use the Employee Enrollment Form.

Must be completed in full - PLEASE PRINT. Change form is not valid without signature(s)

Name of Employer	Employer's Address	
Group Number	Subgroup/Dept #	
Subscriber's Name	SSN/Member #	Effective Date (MM/DD/YYYY)

Old Employee Name	New Employee Name	
New Address		
City	State	Zip Code
Phone Number	Email Address	

Plan/Coverage Selection – Confirm available options with your employer. Select all that apply.

Requested Dental Plan ☐ Copay† ☐ High Deductible Plan†	☐ PPO R&C ☐ PPO MAC	**Dual Option (PPO)** ☐ High ☐ Low	**Network** ☐ Gold ☐ Platinum
Requested Vision Plan	☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other ______		
Requested AD&D Plan	☐ AD&D - Amount ______		

Reason/Status – Required for all requested changes. Notice must be given to Dental Select within 30 days.

☐ Open Enrollment

☐ Rehire
Date of Layoff: ___/___/___ Date of Rehire: ___/___/___

☐ Loss/Gain of Coverage (Employee and/or Dependent)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ Employee Full Time Status Change (PT to FT)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ Other (Mark One)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ Marriage ☐ Termination
☐ Divorce ☐ Birth
☐ Leave of Absence ☐ Adoption
☐ Change of Address ☐ Name Change
☐ Death

☐ Cobra (Mark One)
Date of Change: ___/___/___ Effective Date: ___/___/___

☐ 18 months - Termination
☐ 36 months - Divorce, Loss of Subscriber, Etc.

Cancel (as Indicated)
Cancel Date: ___/___/___

☐ Entire Policy
☐ Dental
☐ Insured Vision
☐ AD&D
☐ COBRA
☐ Dependent (As indicated herein)

Individuals Covered – List individuals and select plan options.

☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Spouse Name (Last, First, M.I.) Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.) Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.) Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.) Gender: ☐ Male ☐ Female	SSN	Date of Birth
☐ Add ☐ Terminate ☐ Change	☐ Dental ☐ Vision ☐ AD&D ☐ COBRA	Dependent Name (Last, First, M.I.) Gender: ☐ Male ☐ Female	SSN	Date of Birth

Authorization of Change (Required for all requested changes. Notice must be given within 30 days.)

Please note that changes may result in premium adjustments.

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.

In the event there is a discrepancy regarding any information contained in this form, documentation will be required.

Employer Signature (Required) ______ Title ______ Date Signed (MM/DD/YYYY) ______

Subscriber Signature ______ Date Signed (MM/DD/YYYY) ______

* Discount program is not underwritten by ACE American Insurance Company.
† Currently Available Only in TX and UT.

Dental Select 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, Utah 84070 · 800-999-9789
Toll Free Fax: 888-998-8704

Formulario de Cambio de Empleado

DentalSelect

Utilice el formulario de cambio de empleado para cancelar o para modificar las opciones del plan de un miembro o una persona a cargo. Para empleados nuevos, utilice el formulario de inscripción de empleado.

Se debe completar en su totalidad — EN LETRA DE IMPRENTA El formulario de cambio no es válido si no está firmado.

Nombre Completo del Empleador	Dirección del empleador	
Número de Grupo	Número de Departmento/Subgrupo	
Nombre del Titular del Seguro	Número de Seguro Social/Numero de Membresía	Fecha de Vigencia (DD/MM/AAAA)

Nombre del Empleado Anterior	Nombre del Empleado Nuevo	
Dirección Nueva		
Ciudad	Estado	Código Postal
Número de Teléfono Residencial	Email Address	

Selección de cobertura/plan — Confirme las opciones disponibles con su empleador. Seleccione las opciones que correspondan.

Plan Dental Solicitado
- ☐ Copay†
- ☐ High Deductible Plan†
- ☐ PPO R&C
- ☐ PPO MAC

Opción Doble (PPO)
- ☐ High
- ☐ Low

Red
- ☐ Gold
- ☐ Platinum

Plan de Vision Solilcitado ☐ Vis 6 ☐ VIs 8 ☐ Vis 12 ☐ Vis 21 ☐ Other ___________________

Plan de AD&D Solilcitado ☐ AD&D - Amount _____________________

☐ Inscripción Abierta

☐ **Volver a Contratar** Fecha de Despido: ___/___/___
Fecha de reincorporación: ___/___/___

☐ **Pérdida o Recuperación de la Cobertura (Empleado y/o Persona a Cargo)** Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___

☐ **Cambio de Estado a Empleado de Tiempo Completo (Medio Tiempo a Tiempo Completo)**
Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___

☐ **Otro (marque una opción)**
Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___
- ☐ Matrimonio
- ☐ Divorcio
- ☐ Licencia sin goce de sueldo
- ☐ Cambio de dirección
- ☐ Muerte
- ☐ Cese
- ☐ Nacimiento
- ☐ Adopción
- ☐ Cambio de nombre

☐ **COBRA (marque una opción)**
Fecha de Cambio: ___/___/___
Fecha de Vigencia: ___/___/___
- ☐ 18 meses — Cese
- ☐ 36 meses — Divorcio, pérdida de titular, etc.

Cancelación (según se indica)
Fecha de cancelación: ___/___/___
- ☐ Póliza Completa
- ☐ Dental
- ☐ Seguro de Visión
- ☐ AD&D
- ☐ COBRA
- ☐ Persona a cargo (según se indica a continuación)

Personas Cubiertas—Enliste a las personas y seleccione las opciones del plan a las que afectarán estos cambios.

☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre del Cónyuge (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento
☐ Agregar ☐ Anular ☐ Cambiar	☐ Dental ☐ Vista ☐ AD&D ☐ COBRA	Nombre de la Persona a Cargo (Apellido, Nombre, Inicial del Segundo Nombre)		
		Sexo: ☐ Masculino ☐ Femenino	Número de Seguro Social	Fecha de Nacimiento

Autorización de cambio (Requerida para todos los cambios solicitados. Se debe notificar en un plazo de 30 días.)

Tenga en cuenta que los cambios pueden provocar ajustes en la prima.

ADVERTENCIA: PROPORCIONAR INFORMACIÓN FALSA O TERGIVERSADA A UN AGENTE ASEGURADOR CON EL PROPÓSITO DE ESTAFAR AL ASEGURADOR O A CUALQUIER OTRA PERSONA SE CONSIDERA UN DELITO. LAS PENAS INCLUYEN PRISIÓN Y/O MULTAS. ADEMÁS, UN ASEGURADOR PUEDE NEGAR LOS BENEFICIOS DEL SEGURO SI EL SOLICITANTE PROPORCIONÓ INFORMACIÓN FALSA ESENCIALMENTE RELACIONADA CON UN RECLAMO.

En caso de que exista una discrepancia con respecto a algún dato que contenga este formulario, se le solicitará documentación.

Firma del Empleador (Obligatorio) _______________ Cargo _______________ Fecha de la firma (MM/DD/YYYY) _______________

Firma del titular _______________ Fecha (DD/MM/AAAA) _______________

* El programa de descuento no está respaldado por ACE American Insurance Company.
† Actualmente, solo está disponible en TX y UT. ‡ AD&D = Muerte Accidental y Pérdida de Miembros

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Toll Free Fax: 888-998-8704

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Key Terms

Agent ID: A unique number associated with an agent's account that is assigned upon becoming appointed with Dental Select.

Bifocal Lenses: Corrective lenses for both far away and up close vision correction.

Claim Form: A standard form most commonly submitted by providers that requests a payment of benefits for services rendered.

Contributory: When both employers and employees contribute a portion of the group insurance premium.

Conventional Contact Lenses: Non-disposable contact lenses designed for long-term use.

Co-pay: The fixed dollar amount required at the time when service is rendered.

Dependent: A child or person for whom another person such as a parent or relative may claim a personal exemption tax deduction. A dependent is a member but not the subscriber on the plan.

Effective Date: The date insurance coverage starts.

Eligible Dependent: A dependent of an insured person who is eligible for dental coverage.

Eligible Employee: An employee who is eligible for benefit coverage, based on the requirements of their employer's dental plan.

Fully insured: When the employer pays a monthly premium and in return the insurance company assumes the risk for claims costs.

Member: Any individual enrolled and covered by a Dental Select plan. Both the subscriber and the dependent are considered members.

Member ID: A unique number assigned to identify an individual covered by a Dental Select plan.

Open Enrollment: the period of time when eligible employees and their dependents can enroll or make changes to their Dental Select plan.

Subscriber (a.k.a. employee): The person whose employment makes him or her eligible for group vision benefits. All others enrolled on the plan are dependents.

Voluntary: When employees are responsible for group insurance premiums; they decide whether or not they want to participate.

FAQs

How do I request a quote?
You may email your request to quotes@dentalselect.com

What do I need to include with a quote request?
Please submit the following information with your quote request, if applicable:

- Plan(s) requested to quote
- Current group census

What do I need to submit with a new group?
A list of required information is included on the New Group Submittal Checklist. It can also be found under Forms at dentalselect.com.

What if I'm not appointed with Dental Select?
You may still submit the request for a quote without being appointed; however, to complete a group sale, you will need to be appointed. Digital appointment documents can be conveniently submitted at dentalselect.com on the broker page.

How soon can I expect to receive my quote?
Dental Select has a 24-hour turnaround time on quotes for groups under 100 lives, and less than 72-hour turnaround time on larger group quotes.

How soon will members get their ID cards?
ID cards can be mailed to the group for distribution or directly to the member's home and will arrive approximately 7 – 10 working days from the time all documentation is delivered and the new group set up is complete. If ID cards are lost, they can also be accessed through the Dental Select mobile app or by logging into the member web portal.

Is LASIK or PRK covered?
Members will receive a 15% discount off the retail price or 5% off the promotional price for LASIK or PRK when visiting a contracted provider.

Who can I call for assistance?
Please contact your Dental Select sales executive or your account representative for assistance. Customer Care, where we have a direct broker queue, is also available for phone inquiries by calling 800-999-9789 Monday through Friday 7:00 a.m. to 6:00 p.m. (Mountain Time).

To request a quote, contact Dental Select:

800-999-9789 | quotes@dentalselect.com

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Dental Select partners with EyeMed to ensure your clients have access to the quality products and national network they want.

DentalSelect eyemed

We've Got You Covered Nationwide.

- Access to 98,000+ independent practitioners
- More than 25,000 location nationwide

Enhance Client Benefits With Vision

Vision benefits are a simple way to add additional value to an employee benefit package. Available as a Contributory or Voluntary option.