



EMPLOYER APPLICATION FOR EXECUTIVE DENTAL COVERAGE

EMPLOYER INFORMATION	
Company Name _____	
Address _____	
City _____	State _____ Zip _____
Contact Person _____	Phone _____ Fax _____
E-Mail Address _____	Nature Of Business _____
Effective Date of Coverage ____/____/____ Note: Effective Date Of Coverage Must Be First Day Of The Month.	

PLAN REQUESTED		
Red Plan <input type="checkbox"/> 3 Or More Lives Enrolled	White Plan <input type="checkbox"/> 10 Or More Lives Enrolled	Blue Plan <input type="checkbox"/> 10 Or More Lives Enrolled
Deductible \$50/\$150 Coinsurance 100%/80%/50% Annual Maximum \$1,000	Deductible \$50/\$150 Coinsurance 100%/80%/50% Annual Maximum \$1,500	Deductible \$50/\$150 Coinsurance 100%/80%/50% Annual Maximum \$2,000
<i>Note: Deductible Waived For Preventive Care.</i>		

OPTIONAL ORTHODONTIA BENEFIT	
50% to \$1,000 Lifetime Maximum for Children under the Age 19. Add Additional \$8.00 to PPO Option Family/Two Party Rate Only. (Available on PPO Option For Groups Enrolling 20 or More Employees Only.)	
Note: CapDent and Managed Care Options Includes Orthodontia on All Size Groups at No Additional Charge.	
Include Benefit <input type="checkbox"/>	Do Not Include Benefit <input type="checkbox"/>

CAPDENT OPTION			MANAGED CARE OPTION			PPO OPTION		
Enrolling	Rate	Subtotal	Enrolling	Rate	Subtotal	Enrolling	Rate	Subtotal
Single	_____ X _____ = \$ _____		Single	_____ X _____ = \$ _____		Single	_____ X _____ = \$ _____	
Empl/Spouse	_____ X _____ = \$ _____		Empl/Spouse	_____ X _____ = \$ _____		Empl/Spouse	_____ X _____ = \$ _____	
Parent/Child	_____ X _____ = \$ _____		Parent/Child	_____ X _____ = \$ _____		Parent/Child	_____ X _____ = \$ _____	
Family	_____ X _____ = \$ _____		Family	_____ X _____ = \$ _____		Family	_____ X _____ = \$ _____	
Subtotal CapDent (A) = \$ _____			Subtotal Managed Care (B) = \$ _____			Subtotal PPO (C) = \$ _____		
Combined Premium (A + B + C) =						\$ _____		
Monthly Billing Fee +						\$ 15.00 _____		
Total Monthly Premium =						\$ _____		

MAKE CHECKS PAYABLE TO: EXECUTIVE DENTAL & VISION

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IMPORTANT Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application.



WAITING PERIOD					
New Employees	<input type="checkbox"/> 0 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> Other ____ Days
<i>Important Note: Coverage For New Hires Begins The First Of The Month Following The Waiting Period</i>					

REPLACEMENT COVERAGE	
No Coverage Currently In Force <input type="checkbox"/>	Coverage Currently In Force <input type="checkbox"/>
There is a 12 Month Waiting Period For Prosthetics, Crowns (And Orthodontia, if Selected) Will Apply For PPO Option: There Are <u>NO</u> Waiting Periods For The CapDent and Managed Care Option.	Waiting Period For Prosthetics, Crowns (And Orthodontia, if Selected) Will Be Waived If Current Plan Covers These Services. Please Provide: Current Bill <input type="checkbox"/> Current Benefit Description <input type="checkbox"/> Waiting Period For Prosthetics, Crowns (And Orthodontia, if Selected) Will Apply To PPO Option For <u>New Employees</u> Only.

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, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF OFFICER	TITLE	DATE
X _____	_____	____/____/____

BROKER INFORMATION	
Broker of Record _____	General Agent _____
Broker Name _____	
Company Name _____	
Address _____ City _____ State _____ Zip _____	
E-Mail _____ Phone (____) _____ Fax (____) _____	
Social Security # _____ or Tax ID # _____ Include Copy Of Current License <input type="checkbox"/>	