CAPDENT / CAPDENT PLUS
GROUP DENTAL APPLICATION
ALL NY INSURED PLANS UNDERWRITTEN BY DENTCARE DELIVERY SYSTEMS, INC.

EMPLOYER INFORMATION

Company Name_____

Address_____

City _____State _____ Zip_____

Contact Person _____Title_____ Phone_____

Group Census _____ Single_____ Two Party_____ Family _____

Requested Effective Date _____/__**1**__/_____

BILLING PERIOD MONTHLY_____ QUARTERLY_____ ANNUALLY_____ OTHER_____

PLEASE CHECK WHICH PLAN: **CAPDENT**_____ **CAPDENTPLUS** _____

All New York groups should submit a copy of their most recent NYS-45 Form.

Coverage for dependents on the CapDent/CapDent Plus ends at age 19, or 25 if full-time student. The minimum number of enrollees in CapDent Plus is three **- there is NO minimum requirement for the CapDent plan with annual billing**. Coverage will begin on the first of the next month if the application, enrollment cards, and payment are received by the 15th of the current month. Premiums are due and are payable at the beginning of each subsequent billing period. Please include the first month's premium (payable to ***Dentcare Delivery Systems, Inc.)*** along with this application. Thank You!

Signature _____Title_____ Date____/_____/_____

BROKER INFORMATION

Sales Representative

Address

City, State, Zip

Phone ( ) Fax ( )

Social Security # *or* Tax ID #

FOR INTERNAL USE ONLY

GROUP #_____ Actual Effective Date_____/__**1**__/_____