



# Master Application for Group Dental Benefits

Effective Date: \_\_\_\_\_

In order for dental coverage to begin on the requested date above, Dental Health Services must receive this application completed no later than the date requested. This application is to confirm your elections and to confirm that the group will adhere to all Dental Health Services plan requirements contained in the group contract. Dental Health Services is unable to issue a contract, group number or billing statement until this application is completed and processed.

## Group Information

Group Name \_\_\_\_\_ Taxpayer ID: \_\_\_\_\_ SIC Code: \_\_\_\_\_

Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Group Administrator \_\_\_\_\_ Type of Business \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_  
(if different from above)

## Number of employees

Total eligible subscribers \_\_\_\_\_

Total participating subscribers \_\_\_\_\_

## Dependent age limits (choose college age limit)

Dependent maximum age is 19.

Full time college student –  23  24  25  26

## Employer contribution

Subscriber \_\_\_\_\_ %

Dependent \_\_\_\_\_ %

## Membership cards sent to

- Employer
- Subscriber's home address

## Benefit selections

Name of selected plan \_\_\_\_\_

## Additional information

New hire eligibility waiting period

- 30 days  60 days  90 days

## Monthly premium rates\*

Subscriber Only \_\_\_\_\_ @ \_\_\_\_\_ = \_\_\_\_\_

Subscriber & 1 dependent \_\_\_\_\_ @ \_\_\_\_\_ = \_\_\_\_\_

Subscriber & 2 dependents \_\_\_\_\_ @ \_\_\_\_\_ = \_\_\_\_\_

Subscriber & 3 dependents \_\_\_\_\_ @ \_\_\_\_\_ = \_\_\_\_\_

First month's premium total: \_\_\_\_\_

\*Please include notes for additional dental plan coverage options with the group's selected dental plan.

## Insurance agent information

Agent name \_\_\_\_\_

Agent number \_\_\_\_\_

## COBRA administration

- Cal-COBRA eligible
- Bill COBRA separately
- The group uses a COBRA administrator

Administrator's name \_\_\_\_\_

Contact person \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

## Group service agreement

Execution of this Application by Group constitutes execution and acceptance by Group of all the terms, provisions, and conditions of the Group Service Agreement. Upon acceptance and execution of the Application by Dental Health Services, the Group Service Agreement shall constitute the Agreement between the parties. Dental Health Services shall then deliver to Group a fully executed copy of the Application and Group Service Agreement.

## Certification

Group hereby applies to Dental Health Services for arrangement of dental care services for Group's eligible employees. It is agreed that dental coverage will not become effective until the Application is completed and has been approved by Dental Health Services, and the applicable premium has been received by Dental Health Services. The insurance agent is not authorized to make any commitments or representations that differ from the Group Service Agreement. Group certifies that the above information is in its entirety true to the best of its knowledge. Group agrees to the terms and conditions of the Group Service Agreement. Group represents that the person signing this application as Group's representative is fully authorized to execute and submit this Application and to enter into the Group Service Agreement on behalf of group.

Group Administrator Signature

\_\_\_\_\_

Approved and Accepted by  
Dental Health Services

\_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_