



3780 Kilroy Airport Way, Suite 750
 Long Beach, CA 90806
 800-637-6453
dentalhealthservices.com

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/CFO _____ Type of Business _____

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

Number of Employees

Total eligible employees _____

Total participating employees _____

Employer Contribution

Employee _____ %

Dependent _____ %

Benefit Selections

Name of selected plan _____

Additional Information

New hire eligibility waiting period

30 days 60 days 90 days

Dependent Age Limits

Dependent maximum age is 26. You may select a lower dependent maximum age, however, it is the group's responsibility to monitor and manage dependent ages other than the standard maximum.

Membership Cards Sent To

- Employer
- Employee's home address

Monthly Premium Rates*

Employee Only _____ @ _____ = _____

Employee & Spouse _____ @ _____ = _____

Employee & Child(ren) _____ @ _____ = _____

Employee & Family _____ @ _____ = _____

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 _____

Phone Number _____

Group Billing Contact

Name _____

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 _____

Website Information Access

Please indicate the level of access you would like to allow for employees. Default access restricts both options.

Change Member Contact Information

Change Dentist Information

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: _____