DentaSpan

DentaSpan Policy Number_____

Underwritten by Dental Care Plus, Inc.
100 Crowne Point Place
Cincinnati, Ohio 45241

APPLICATION FOR MASTER GROUP POLICY

The Enrolling Unit/Employer named below hereby makes application to Dental Care Plus, Inc. for a Master Group Policy to be issued in accordance with the specifications of the Application.

Please Print clearly or Type requested information:

EMPLOYER GROUP INFORMATION

Legal Name of Enrolling Unit/Employer:			
Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:		
Mailing Address (if different from above):	City:	State:	Zip Code:

Legal Status: □ Corporation □ Partnership □ Proprietorship □ Trustee

Other (please specify): ___

Nature of Business or Industry:

Subsidiaries – The following subsidiaries, affiliates or other organizations will be included under this Master Group Policy: ___

ELIGIBILITY

All active, full-time employees, working at least 30 hours per week are eligible:

□ Yes □ No If no, list the classes of employees who are eligible: _____

Total number of full-time, eligible employees: ___

Dependent Eligibility

_____ _____ _____

Employee Waiting Period

New employees will be effective:

□ first of the month following date of hire □ date of hire
□ 30 days, first of following month □ 31st day of employment
□ 60 days, first of following month □ 61st day of employment
□ 90 days, first of following month □ 91st day of employment
□ Other (please specify): ___

DENTAL PREMIUM RATES

All Premium Rates shall be paid by the Enrolling Unit/Employer to Dental Care Plus, Inc. at its Home Office on or before each due date. The first Premium Rate is due on _________________ and subsequent Premium Rates are payable monthly.

Select one tier structure:

Child Only Coverage

□ Two tier rates: One Child: **$**\_\_\_\_\_ Two or More Children: **$**_____

Family Coverage

□ Four tier rates: Single: **$**\_\_\_\_\_ EE& Spouse **$**_____ EE& Child(ren): **$**\_\_\_\_\_ Family: **$**_____

Will the employees be required to contribute toward the cost of the insurance? □ Yes □ No

If yes, indicate the percentage or dollar amount of the cost of each coverage the employee will pay:

Employee: _____

Dependent: _____

EFFECTIVE & ANNIVERSARY DATES

Effective Date: The Master Group Policy will be delivered and governed by the laws of the state where the Policy was issued and shall take effect on _____ but only if this application is accepted in writing by Dental Care Plus, Inc. at its Home Office.

Renewal / Policy Anniversary Date:

_____

BENEFIT PLAN INFORMATION

Benefit Plan Number: _____

	Annual Individual / Family Deductible Amount	**PPO Coinsurance Percentage** In Network / Out of Network
Preventive Benefits	no deductible	_____ / _____
Basic Benefits	**$** _____ / _____	_____ / _____
Major Benefits	**$** _____ / _____	_____ / _____
Orthodontic Benefits	no deductible	_____ / _____

Out of Network Reimbursement Level □ Match

(OON claims are reimbursed at the Match Level for DentaSpan Child Only and Family Coverage)

Variable Options: Preventive Visit Co-pay: **$**_____ (applies to routine exams and cleanings per visit)

Annual Maximum Benefit Per Member Over Age 19: Amount **$**_____ □ Calendar Year □ Plan Year

Orthodontics: Medically Necessary Child Orthodontics (includes eligible dependent Children under age 19)

CONTACT INFORMATION

Please name the **coordinator** of your dental benefit plan:

Name: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Please name the **finance contact** of your dental benefit plan:

Name: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

SIGNATURES

The Enrolling Unit/Employer hereby agrees and understands that the Master Group Policy issued is based on the information provided in this Application, which Enrolling Unit/Employer hereby represents is true and accurate, and that acceptance of the Master Group Policy by the Enrolling Unit/Employer constitutes agreement to all terms and conditions of the Application and the Master Group Policy. The Master Group Policy shall be deemed accepted if it is not returned by the Enrolling Unit/Employer to Dental Care Plus by registered mail within ten (10) business days of receipt. A copy of this Agreement shall be attached to and made a part of the Master Group Policy issued to the Enrolling Unit/Employer. **Dental Care Plus, Inc. reserves the right to rescind the Master Group Policy or to take any other action which Dental Care Plus, Inc. deems necessary if the information provided on this Application is false or inaccurate.**

Ohio Fraud Notice – 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.

For the Enrolling Unit/Employer:

By _____

Title _____ Date _____

For Dental Care Plus, Inc.:

By _____

Title _____ Date _____