Texas Group Plan Application

DentalSelect

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-5328 **DentalSelect.com**

Group Information

Group Name		
SIC Code or Industry	Requested Effective Date	
Street Address		
City	State	Zip Code
Phone	Fax	
Nature of Business		

Billing Address		
City	State	Zip Code
HR Contact & Title		
Phone #	Email	
Billing Contact & Title		
Phone #	Email	

Number in Group	Number Enrolling	☐ Electronic Enrollment (834 file format) For groups 250+ enrolled

Plan Options - Check all that apply.

Plan Type - Select one

☐ Contributory Plan ☐ Voluntary Plan

Dental - Select one

- ☐ **Discount** - Silver Network*
- ☐ **Co-Pay** - Gold Network
- ☐ **Co-Pay** - Platinum Network
- ☐ **PPO Max** - Gold Network
- ☐ **PPO Max** - Platinum Network
- ☐ **Indemnity Max** - Platinum Network

PPO & Indemnity Options

- ☐ **Standard** (w/o Max option)
- ☐ **Preventive & Basic**
- ☐ **Preventive**

*This plan is not underwritten by ACE American Insurance Company

Insured Vision

- ☐ Access Value
- ☐ Access Classic

Access Choice:

☐ Vis4 ☐ Vis8
☐ Vis5 ☐ Vis7
☐ Vis6 ☐ Vis10

Accidental Death & Dismemberment (AD&D) - Select one

- ☐ Employee
- ☐ Employee + Family
- ☐ **AD&D Voluntary** - Amount $ ________________
- ☐ Decline

Beneficiary Designation Required - (Additional form available with Employee Enrollment)

New Hire Waiting Period

Employees will be eligible to enroll the first of the month following the required days of continuous full time employment with the group. Present employees who are eligible must enroll on the policy effective date, or within 31 days of group effective date. New employees must enroll within 31 days of the date they become eligible. **(Please complete employee category section)**

Employee Category - (for new hire waiting periods)

	Days:
	Days:
	Days:
	Days:
	Days:

Contributory Plan Information - (if applicable)

Number of Full Time (at least 30 hrs. per week) Employees: ________________ **Number Waiving Coverage:** ________ **Number Waiving Due to Other Coverage:** ________

Employer Contribution Percentage for Employee: ________________% **Employer Contribution Percentage for Dependant:** ________________%

Does the employer now have a comparable dental plan which has been in force for the past 12 consecutive months?

☐ **Yes** ☐ **No**

The benefit waiting period for basic, major and orthodontic services may be waived only for those employees covered under the company's prior comparable plan. To qualify for the waiting period to be waived, a copy of the prior dental certificate booklet and current bill listing the covered employees eligibility date must accompany this application, or be received by Dental Select **within 45 days of effective date of group**.

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Rates

Dental Plan Name:	#1 ________	#2 ________	#3 ________	Vision	AD&D
	Sold Rates	Sold Rates	Sold Rates	Sold Rates	Sold Rates
Single:	________	________	________	________	________
Employee/Spouse:	________	________	________	________	________
Employee/Children: (if applicable)	________	________	________	________	________
Family:	________	________	________	________	________

Monthly Administration Fee as quoted: $________________
($2.00 per employee: maximum $20.00)

First month's premium must be included with application.

Terms & Conditions

By signing below, company officer or authorized person:

- understands that the In-Network plan providers are not agents, representatives, nor employees of Dental Select.
- represents that all information on this application and any attachment is correct and complete to the best of his/her knowledge and belief.
- understands that no insurance will become effective until approved by the Insurance Company.
- understands that no agent has the authority to modify or waive any conditions of this application or the policy nor to bind the insurance company by making any promise of representation.
- agrees to maintain and furnish any records necessary to administer the policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation requirements must be met before the policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.
- understands that the employer is the plan sponsor and plan administrator and that neither Dental Select or ACE American Insurance Company, nor any insurance agent is a plan administrator nor fiduciary, as those terms are defined under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to participating employer's plan of groups insurance, and the questions regarding the tax or legal effects of the plan are to be resolved by the employer with advice of their own counsel.

The applicant hereby requests insurance for eligible persons based on the above statements and representations, and where applicable, agrees to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the Applicant.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature - Company Officer or Authorized Person ________ Name ________ Date ________

AH-22273–TX

Agent / Broker Information

Agent Name	Email
Agency Name	Agent Phone #
GA (if applicable)	Agent ID #
Agent Signature	Date

NOTE: Please make a copy of this form for your records before submitting.

Dental Select Office Use Only

Approved by	Date Approved	Title
Effective Date		Group #

DentalSelect

5373 S. Green Street, 4th Floor
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User Type

☐ Group ☐ Member ☐ Agent/Broker (If the user type is Agent/Broker, you MUST attach the group's authorization email.)

Administrator Information

Group Name:

Group Number:

SE for Group:

Group Type: ☐ Fully – Insured ☐ Self – Funded*

User Information

User First Name:

User Last Name:

Is this proposed user a Dental Select member? ☐ Yes ☐ No

User's Date of Birth:

User Email Address:

* Special Notes or Exceptions: