

# NEW BUSINESS SUBMISSION FORM

## Policy Administration Information

The following information needs to be completed in order to assist IHC Health Solutions in administering your dental plan. Please place a check mark in the appropriate box or circle where indicated.

Employer Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Employer Email Address: \_\_\_\_\_

Agent Email Address: \_\_\_\_\_

### INITIAL ENROLLMENT PROCESS

*Employer wishes to submit initial enrollments as follows (check one):*

- Online enrollment via the Internet (IHC Health Solutions will advise password)
- Download and forward data from Employer's database on diskette or E-mail to IHC Health Solutions (circle one).
- IHC Health Solutions will provide a CD-ROM for data to be entered by Employer and forwarded to carrier.
- Submit hardcopy enrollments to **IHC Health Solutions** or **Agent** (circle one) (IHC Health Solutions provide forms).

### ONGOING ENROLLMENT PROCESS

*Employer wishes to submit ongoing enrollments as follows (check one):*

- Online enrollment via the Internet (IHC Health Solutions will advise password)
- Download and forward data from Employer's database on diskette or E-mail to IHC Health Solutions (circle one).
- IHC Health Solutions will provide a CD-ROM for data to be entered by Employer and forwarded to carrier.
- Submit hardcopy enrollments to **IHC Health Solutions** or **Agent** (circle one) (IHC Health Solutions provide forms).

### ADMINISTRATION KITS (WELCOME TO IHC HEALTH SOLUTIONS)

*IHC Health Solutions to forward the Admin Kit and Instruction Guide to (check or circle as indicated):*

- Send via Internet to Agent or Employer (circle one).
- Send data on CD-ROM or ZIP Drive (circle one) to Agent or Employer (circle one).
- Submit hardcopy directly to **Agent** or **Employer** (circle one).

### DENTAL INSURANCE POLICY AND CERTIFICATES

*IHC Health Solutions to forward the Policy and Certificates as follows (check or circle as indicated):*

- Send via Internet to Agent or Employer (circle one).
- Send data on CD-ROM or ZIP Drive (circle one) to Agent or Employer (circle one).
- Submit hardcopy directly to **Agent** or **Employer** (circle one).

**Note: Based on Insurance Regulations, it is required that the Employer provide the Insurance Certificates to the Employees either as a hardcopy or through online access.**

The undersigned acknowledges the above instructions and understands the importance of providing the Employees the Insurance Certificates immediately upon receipt.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date

**EMPLOYER DENTAL INSURANCE APPLICATION** PLEASE PRINT (WITH INK) IN THE SPACES PROVIDED BELOW

**GROUP INFORMATION**

Legal Name of Employer:			
Applicant's Phone Number:		Federal Tax ID No.	
Nature of Business:		SIC Code:	
Billing Address:	City:	State:	Zip Code:
Street Address (if different from above):	City:	State:	Zip Code:
Name of Subsidiaries, Divisions. Locations or Affiliates to be Covered:			
Name and Title of Employer Plan Administrator/Human Resources Contact:		Phone Number: ( )	Fax Number: ( )
Proposed Effective Date of Insurance:			
Advance payment of \$_____ is submitted herewith to be applied by the Company to premiums for insurance when and if issued.			

**ELIGIBILITY**

Eligible Classes: ____ Minimum Hours Per Week <input type="checkbox"/> All Full Time Employees <input type="checkbox"/> Retirees <input type="checkbox"/> Other _____ Number Eligible ____ Any excluded classes of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details _____	Employee Benefit Waiting Period:  Current Employees: _____ Day Waiting Period  New Employees: _____ Day Waiting Period
---	--

**Effective Date of Coverage / Termination Date of Coverage**

- Option 1**  Effective the first day of the month coincident with or next following the date the Employee Benefit Waiting Period is completed and application is approved/terminated on the last day for which premium has been paid.
- Option 2**  Effective immediately/terminated on the last day for which premium has been paid.

Note: Option 1 always applies to voluntary coverage.

**PRIOR CARRIER INFORMATION**

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

\_\_\_\_\_ Termination Date  
 \_\_\_\_\_ Carrier Name

For Credit for Prior Coverage to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each insured individual and dependents, if insured.

**PREMIUM / MONTHLY COST**

**Select one tier structure:**

**Dental Option 1**

- Composite rate: \$\_\_\_\_\_
- Two tier rates: Single: \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Three tier rates: Single: \$\_\_\_\_\_ EE& One Dependent: \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Four tier rates: Single \$\_\_\_\_\_ EE&Spouse \$\_\_\_\_\_ EE/Child(ren): \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Five tier rates: Single: \$\_\_\_\_\_ EE&Spouse: \$\_\_\_\_\_ EE& 1 Child: \$\_\_\_\_\_ EE&Children: \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ EE&Spouse \$\_\_\_\_\_ EE& 1 Child \$\_\_\_\_\_ EE&2 or 3 deps \$\_\_\_\_\_ EE&4or more deps \$\_\_\_\_\_

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

If yes, indicate the percentage of the cost of each coverage the employee will pay.

Coverage	EE Dental	Dep Dental	EE Vision	Dep Vision
Employee % or Dollar amount				

Note: If the employer pays the entire cost for the **employees**, then 100% of the eligible employees **must** apply for coverage.

**DENTAL COVERAGE INFORMATION**

**Employee Plan Option 1:** \_\_\_\_\_

**Select One**

	<b>Benefit Waiting Period</b>	<b>Deductible Amount per Person (check one)</b> <input type="checkbox"/> Annual <input type="checkbox"/> Lifetime	<input type="checkbox"/> <b>Indemnity Coinsurance Percentage</b>	<input type="checkbox"/> <b>PPO Coinsurance Percentage</b> (In Network/Out of Network)
Preventive Care	_____	_____	_____	_____
Diagnostic Care	_____	_____	_____	_____
Basic Care	_____	_____	_____	_____
Major Care	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____

Office Visit Co-pay: \$\_\_\_\_\_

Other Co-pays \$\_\_\_\_\_ Applied to: \_\_\_\_\_

Dental Maximum (except ortho) Calendar Year  Plan Year  Amount \_\_\_\_\_

Orthodontics  Yes  No If Yes, Calendar Year Limit \$\_\_\_\_\_ Lifetime Maximum \$\_\_\_\_\_

Dental PPO  Yes  No Network \_\_\_\_\_

**Optional Benefits (additional premium may be required)**

Deductible credit/Annual maximum credit (only available on calendar year plans):  Yes

Cosmetic Procedures (this box needs to be checked and additional premium paid to add this coverage)  Yes

Posterior Composites (this box needs to be checked and additional premium paid to add this coverage)  Yes

Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage)  Yes



# Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number \_\_\_\_\_  
 Group Number \_\_\_\_\_
2. Total number of employees on payroll \_\_\_\_\_
3. Total number of employees working 1-29 hours per week (include temporary and/or seasonal employees) \_\_\_\_\_
4. Total number of employees in waiting period \_\_\_\_\_
5. Number of full-time eligible employees (subtract numbers 3 and 4 from number 2) \_\_\_\_\_

If you have purchased an employee paid voluntary group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above. No waivers for coverage under another program will be allowed in this calculation.

For employer paid group coverage (with rates calculated from a census), the number of employees listed in number 6 and 7 below may be subtracted from the number of full time employees shown in number 5 above. Participation requirements will be calculated from that number.

6. Total number of employees enrolled in a DHMO or qualified Discount/Referral plan (proof must be submitted) \_\_\_\_\_
7. Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file) \_\_\_\_\_
8. Number of eligible employees (subtract 6 & 7 from 5) \_\_\_\_\_
9. Number of full-time employees enrolled \_\_\_\_\_
10. Premium information: \_\_\_\_\_ 100% employer paid **OR** employer pays \_\_\_\_\_% of employee premium and \_\_\_\_\_% of dependent premium.

### Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by GroupLink, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Signature of Writing Agent                      Agent Code

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Type or Print Agent's Name(s)

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Agent's Business Address (City, State & Zip Code)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency    Agency Code

\_\_\_\_\_  
Company Name

