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NEW GROUP SUBMISSION PROCESS

Submission Date: New group information must be postmarked no later than the 30th of the month to be effective for the first of the following month.

NEW BUSINESS CHECK LIST

Please confirm that the following is submitted with all new cases.

- ❑ Completed Employer Application (with company email address)
- ❑ Completed Employee Enrollment Forms Including Waivers
- ❑ First Month's Premium (Made payable to: Employer Plan Services, Inc.)
- ❑ Copy of Quote
- ❑ Producer Licensing Forms (if not previously contracted)

TAKEOVER BENEFIT COVERAGE

Please confirm that all of the following documentation is provided for prior coverage on takeover cases:

- ❑ Copy of prior Plan, Schedule of Benefits and Rates
- ❑ Copy of Prior Plan's Last Statement

SUBMIT ALL ORIGINAL FORMS TO:

cbg
5006 Lyndale Avenue South
Minneapolis, MN 55419
(612) 827-0855 or toll free (888) 327-8880

Employer Application

Group Dental Coverage

Provided by United HealthCare Insurance Company

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Company Name:		
Address:		City
State:	Zip Code:	Phone Number:
Fax Number:		Contact Name:
E-Mail Address of Contact:		

EMPLOYER INFORMATION

Organization Type: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Political Subdivision[1] ☐ Other

[1]Submit legal opinion or minutes from Board Meeting along with application showing consent.

Full Legal Name of Employer:
Include names of subsidiaries or affiliated companies

Employer Identification Number (Tax ID):	Subject to ERISA? ☐ Yes ☐ No

Has your firm ever filed for or is it in the process of filing for bankruptcy? ☐ Yes ☐ No

DENTAL PLAN PARTICIPATION AND SELECTION

Did the group have dental coverage for the past [12] months? ☐ Yes ☐ No	If yes, name of prior dental carrier:

Requested effective date of coverage: ____/ ____/ _____ All effective dates must be first of the month.

Total number of employees on payroll:	Total number of full time/eligible employees (EE):	
Multi Site: ☐ Yes ☐ No	Number of Locations:	Locations:
Number of COBRA participants in total group:		Number of Retirees in total group:

Dental Plan Selected:

Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	EE				
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

Amount of Binder Check:
***This check must accompany the group application.

BILLING AND CONTACT INFORMATION

Please provide the information below if different than above for billing purposes and plan administration.

Address		
City:	State:	Zip Code:
Contact Name:	Phone:	
Fax:	E-Mail Address:	

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of [31] days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the group policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage.

I agree that the company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

Authorized Officer’s Name:	Title:
Authorized Officer’s Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date:
Agency Name:	
General Agency Name:	

Dental Enrollment Form

Group Dental Coverage Provided by
United HealthCare Insurance Company

CONFIDENT℠ by cbg

Enroll Dental ___ Vision ___

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	☐ Enroll ☐ Cancel ☐ Waive for other coverage DATE : / /

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER HOME ( ) WORK ( )		☐ Male ☐ Single	☐ Female ☐ Married

APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Employee ☐ Employee + Spouse (or Domestic Partner) ☐ Employee + Child(ren) ☐ Family

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship			If Child is over 19, please indicate status and school	
		☐ Wife ☐ Husband ☐ Domestic Partner		☐ M ☐ F	☐ Student at: ____________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ____________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ____________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ____________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ____________ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel

*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION
EFFECTIVE DATE
TYPE OF COVERAGE

SIGNATURE ____

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

MINIMUM ENROLLMENT IS FOR ONE YEAR

CONFIDENT℠ by cbg Dental PPO Plans are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York), United HealthCare Insurance Company of New York; Hauppauge, New York (New York Only).