DentalSelect

Group Plan Application

Toll Free: 800-999-9789 Toll Free Fax: 888-998-8709 DentalSelect.com

Group Information

Group Name			Billing Address		
Employer EIN	Requested Effective Date		City	State	Zip Code
Mailing Address			HR Contact & Title		
City	State	Zip Code	Phone #	Email	
Phone #	Fax #		Billing Contact & Title		
Nature of Business	SIC Code or Industry		Phone #	Email	

Design Your Plan

Select Preferred Enrollment

☐ **Electronic Enrollment (834 File Format)** For groups 50+ enrolled. ☐ **Spreadsheet** (Dental Select authorized form only) ☐ **Paper Forms**

☐ **Dental Only** ☐ **Dental & Vision** ☐ **Vision Only**

Dental Plan Options - Utah & Texas Only

Funding: ☐ Contributory Plan ☐ Voluntary Plan

Type: ☐ Classic ☐ Choice

Dental Plan: ☐ Discount - Silver Network* ☐ Co-Insurance PPO** ☐ Co-Pay ☐ Co-Insurance Indemnity

Network:** ☐ Gold ☐ Platinum ☐ Signature

AD&D Plan Option: ☐ Employee ☐ Employee & Family ☐ Contributory - Amount $ ____________ ☐ Voluntary

Beneficiary Designation Required - (Additional form available with Employee Enrollment) Principal Sums range from $10,000 to $250,000. Refer to plan flyer for specifications.

Dental Plan Options - All Other States

Funding: ☐ Contributory Plan ☐ Voluntary Plan

Type: Choice

Dental Plan: ☐ Co-Insurance PPO/MAC ☐ Co-Insurance Passive PPO

Network: Network availability listed by state in the Participation Guidelines.

Select a Vision Plan - All States

Funding: ☐ Contributory Plan ☐ Voluntary Plan

Plan: ☐ Vis 6z ☐ Vis 7z ☐ Vis 8z ☐ Other ____________________________

General Participation

Number of Full Time (at least 30 hr. per week) Employees: _______________

Number of Dental Employees Enrolling: ____________

Number Waiving Due to Other Dental Coverage: ____

Employer Contribution Percentage for Employees: _______________ %

Employer Contribution Percentage for Dependent: _______________ %

Number of Vision Employees Enrolling: ___________

Calculate Your Rates – Based on plan design, complete rates below

	#1 ____________ Sold Rates	#2 ____________ Sold Rates	#3 ____________ Sold Rates	Vision Sold Rates	AD&D Sold Rates
Single:	____________	____________	____________	____________	____________
Employee/Spouse or E1D:	____________	____________	____________	____________	____________
Employee/Child(ren):	____________	____________	____________	____________	____________
Family:	____________	____________	____________	____________	____________

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

First month's premium must be included with application.

*Discount plan is not underwritten by ACE American Insurance Company
** Where permitted by law

New Hire Waiting Periods

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 below)**

Employee Category

How long must a new hire be employed before being offered benefits? Benefits are available the first day of the month following:

- ☐ Date of Hire
- ☐ Exact date of hire
- ☐ 30 Days
- ☐ Waive at initial enrollment only
- ☐ 60 Days
- ☐ Other: ________________
- ☐ 90 Days

Is the new hire waiting period different for any class of Employees (i.e. hourly/salary/management/non-management)? If yes, please identify below. **Minimum of 2 per class.**

Class:	New Hire Waiting Period Days:
________________	________________
________________	________________
________________	________________
________________	________________

Comparable Dental Plans

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

☐ **Yes** ☐ **No**

If Yes:

Name of carrier: ________________________________ **Length of coverage:** ________________________________

Waiting Period Waiver

☐ Waiting Periods ☐ Orthodontic

Waiting Periods Waived for Prior Comparable Coverage:

With proof of coverage and Member's effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior comparable coverage must accompany the application in order to reduce waiting periods.

The waiting periods for Basic, Major and Orthodontic services may be waived (in part or in their entirety) only for those Employees and Dependents covered on the Group's prior comparable plan.
To qualify for a waiver, the following documentation must accompany this application:

- Prior carrier's Summary of Benefits
- Most recent Billing Statement, listing the covered employees eligibility date

Take-over Provisions

☐ Maximums & Deductibles

When take-over applies, both the maximum and deductible will be reviewed for take-over together. **To qualify for a take-over, the following documentation must accompany this application:**

- The total and any amount applied, per member for both maximum and deductibles

Terms & Conditions

By signing on the next page, 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.

(Continued on next page)

Terms & Conditions (continued)

(Continued from previous page)

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.

Fraud Warning for Kentucky Applicants:
WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Signature - Company Officer or Authorized Person | Printed Name | Date

AH-29593

How To Submit Your Information

The first month's premium must accompany the application. Thereafter, Dental Select must receive the premium by the first day of each month to the P.O. Box address listed in the administrative guide.

1. Complete group plan application. Retain a copy for your files.
2. Have each employee complete and sign an employee enrollment form.
3. Submit electronic enrollment (834 file format) for groups 50+ employees enrolled (ongoing).
4. Send the original group plan application, completed employee enrollment forms and the first month of premium **payable to Dental Select** to:

Dental Select
5373 South Green Street, 4th Floor
Salt Lake City, UT 84123
Toll Free Fax: 888-998-8704

Any questions? Call 800-999-9789.

Please Select Payment Option:

☐ **EFT Electronic Funds Transfer** – Groups must enroll for recurring EFT on Web Portal. Initial premium MUST be submitted as a Binder Check.

☐ **Monthly Billing Invoice**

Agent / Broker Information

Agent Name		Email	
Agency Name		Agent Phone #	
GA (if applicable) GIS/MARK METTILLE		Agent ID #	
Agent Signature		Date	
Agent Address	City	State	Zip Code

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 #	Subgroup #

DENTALSELECT

5373 South Green St. 4th Floor
Salt Lake City, UT 84123
801-495-3000 800-999-9789
Fax 888-998-8709

ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.

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Employee Enrollment Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect**.com

DentalSelect

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

☐ No Benefit ☐ Dental ☐ Vision ☐ AD&D	**First Name**	**Last Name**
Mailing Address		
City	**State**	**Zip Code**
Phone	**Date of Birth** (MM/DD/YYYY)	
SSN/Member ID#	**Marital Status** ☐ Married ☐ Single	**Gender** ☐ Male ☐ Female
Effective Date (MM/DD/YY)	**Date of Hire (Required)** (MM/DD/YY)	
Group Number	**Subgroup/Dept. #**	
Employer's Full Name		
Employer's Address		

Coverage Selection - Confirm available options with your employer. Check all that apply.

Dental Plan

☐ Discount - Silver
☐ Co-Pay - Gold
☐ Co-Pay - Platinum
☐ Co-Insurance PPO* - Gold
☐ Co-Insurance PPO* - Platinum
☐ Co-Insurance Indemnity - Platinum

* Where permitted by law

☐ Co-Insurance PPO/MAC - Platinum
☐ Co-Insurance Passive PPO - Platinum
☐ ACA EHB Child Only
☐ Other ___________________

Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.

☐ High ☐ Low

Vision Plan

☐ Vis 1 ☐ Vis 2 ☐ Vis 3 ☐ Vis 4 ☐ Vis 5 ☐ Vis 6
☐ Vis 7 ☐ Vis 8 ☐ Vis 9 ☐ Vis 10 ☐ Vis 11
☐ Other ______________

AD&D Plan Option - Utah & Texas Only

Contributory - Amount $_______________

☐ Employee (Complete beneficiary info on Designation Form)
☐ Employee & Family (Complete individuals covered and sign page 2)

Voluntary

☐ AD&D - Amount $_______________ (Complete beneficiary info on Designation Form)
Principal Sums range from $10,000 to $250,000. Refer to plan flyer for specifications.

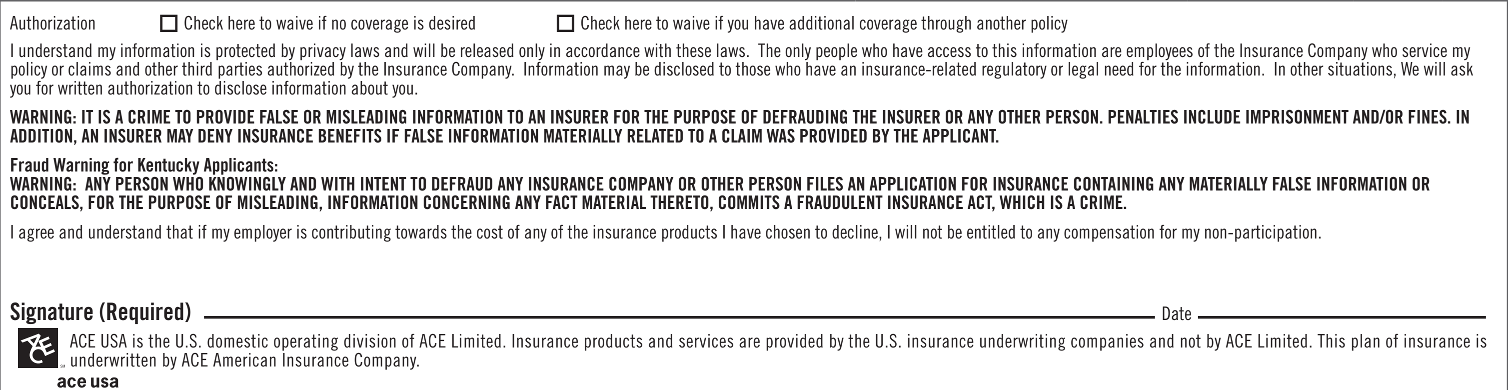
Individuals Covered - List individuals for whom you are enrolling and select plan option.

		Gender	SSN	Date of Birth
☐ Dental ☐ Vision ☐ AD&D	**Spouse Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	**Dependent Name -** (Last, First, MI)	**Gender** ☐ Male ☐ Female	**SSN**	**Date of Birth** - (MM/DD/YYYY)

For additional dependents include the Dependent Enrollment Form

Covered by other DENTAL Insurance? ☐ Yes ☐ No	**If Yes,** Name of other Dental Insurance Company	Name of Person Insured	Social Security Number

Authorization of Coverage



Authorization ☐ Check here to waive if no coverage is desired ☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

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I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

Signature (Required) ______________________________ Date ______________

ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.

ace usa

DentalSelect

Employee Change Form

Toll Free: 800-999-9789 **Toll Free Fax:** 888-998-8704 **DentalSelect.com**

Subscriber Information

Group Name:	Group #:	Sub-Group #:
Subscriber Name (Please Print):		SSN or Member #:

Requested Change - Complete applicable section below

Name Change

From (Name):	To (Name):

Address Change

New Address:	
City/State/Zip:	Telephone:

Policy Change

Plan Change

- ☐ Effective Date:________________________
  - ☐ Add Dependents as Indicated
  - ☐ Add or Change Dental Plan (request plan below)
  - ☐ Add or Change Insured Vision (request plan below)
  - ☐ AD&D (A beneficiary change requires a Beneficiary Designation From which is submitted to and kept by the employer.)
- ☐ COBRA
  Effective Date: _____________________
  - ☐ 18 Months – Termination or from Full to Part-time
  - ☐ 36 Months – Divorce, loss of Subscriber or loss of dependent child status

Cancel

(Cancel as indicated)

- ☐ Entire Policy
- ☐ Dependent (as indicated below)
- ☐ Dental
- ☐ Insured Vision
- ☐ AD&D
- ☐ COBRA
  Cancellation Date: _______________

Requested Dental Plan:

- ☐ Discount - Silver
- ☐ Co-Pay - Gold
- ☐ Co-Pay - Platinum
- ☐ PPO - Gold
- ☐ PPO - Platinum
- ☐ Indemnity - Platinum
- ☐ Dual Option
  - ☐ High
  - ☐ Low
- ☐ Other _________________

Requested Vision Plan:

- ☐ Access Value
- ☐ Access Classic
- Access Choice
  - ☐ Vis 4
  - ☐ Vis 5
  - ☐ Vis 6
  - ☐ Vis 7
  - ☐ Vis 8
  - ☐ Vis 10

☐ **Delete / Add ONLY Dependants Listed Below** - Effective Date:___________________________

☐ Add ☐ Delete	☐ Dental ☐ AD&D ☐ COBRA ☐ Vision	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN:
☐ Add ☐ Delete	☐ Dental ☐ AD&D ☐ COBRA ☐ Vision	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN
☐ Add ☐ Delete	☐ Dental ☐ AD&D ☐ COBRA ☐ Vision	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN
☐ Add ☐ Delete	☐ Dental ☐ AD&D ☐ COBRA ☐ Vision	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN
☐ Add ☐ Delete	☐ Dental ☐ AD&D ☐ COBRA ☐ Vision	Last Name:	First:	MI:	Relation:	Sex:	Birth Date:	SSN

Reason/Status Change
(Required for all requested changes) Notice must be given to Dental Select within 30 days

- ☐ Marriage - Date:___________
- ☐ Loss/Gain of Other Coverage - Date: __________
- ☐ Divorce - Date:____________
- ☐ Death
- ☐ Birth
- ☐ Adoption
- ☐ Open Enrollment
- ☐ Terminated Employment Date: _________________
- ☐ Full to Part-Time (will result in coverage termination)
- ☐ Court Ordered (Requires documentation)

Signature Authorization

Employer Name: ________________________________ Title:_____________________ Employer's Signature:	Date Signed (MM/DD/YYYY):
Subscribers Signature:	Date Signed (MM/DD/YYYY):

Please Note That Changes May Result in Premium Adjustments

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In the event there is a discrepancy regarding any information contained in this form, documentation will be required.

Mail: Dental Select (Attn: Eligibility) 5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123 Fax: (801) 290-5101 Toll Free Fax: (888) 998-8704