



SMALL BUSINESS GROUP APPLICATION

EMPLOYER INFORMATION					
Company Name				Group #	
Address		Suite #	City	State	Zip Code
Contact Person			Title	Phone	
GROUP ENROLLMENT CENSUS				EMAIL ADDRESS	EFFECTIVE DATE
Single	Two Party	Family	Total Enrollment		
MONTHLY PREMIUM RATES					
Single:\$ _____		Two Party:\$ _____		Family:\$ _____	
PAYMENT					
CHECK					
Check enclosed in the amount of \$ _____ payable to Professional Group Plans, Inc. representing initial month's premium.					
CHECKLIST OF ENCLOSURES					
<input type="checkbox"/> Signed Group Application		<input type="checkbox"/> Initial monthly premium payment by check (enclosed)			
<input type="checkbox"/> Group Enrollment form(s) for each employee					
<input type="checkbox"/> Most recent NYS-45 Quarterly Tax Report					
BROKER/AGENT APPOINTMENT					
Broker/Agent				SSN/Tax ID#	
Broker/Agent				SSN/Tax ID#	
<i>By signing below, I acknowledge that I have read and agree to the terms and conditions on the reverse side.</i>					
<i>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</i>					
Signature				Date	

PLAN SELECTION					
<input type="checkbox"/> CapDent	<input type="checkbox"/> CapDent Plus	<input type="checkbox"/> Select	<input type="checkbox"/> Select Plus	<input type="checkbox"/> Omni	<input type="checkbox"/> Comprehensive Voluntary
Minimum Enrollment of 2 Employees	Minimum Enrollment of 3 Employees	Minimum Enrollment of 2 Employees	Minimum Enrollment of 3 Employees	Minimum Enrollment of 2 Employees	<input type="checkbox"/> Low Option <input type="checkbox"/> Medium Option <input type="checkbox"/> High Option <input type="checkbox"/> High Enhanced Option
SUPPLEMENTAL/ADDITIONAL INFORMATION (INTERNAL USE ONLY)					
Benefits are per: <input type="checkbox"/> Contract Year			Days to Renew: <input type="checkbox"/> 60		
Vision					
<input type="checkbox"/> V0 - No Vision		<input type="checkbox"/> V2 - Comprehensive Funded II		<input type="checkbox"/> V4 - Designer Materials	
<input type="checkbox"/> V1 - Comprehensive Funded I		<input type="checkbox"/> V3 - Affinity Hybrid		<input type="checkbox"/> V5 - Comprehensive Designer	
<input type="checkbox"/> VV - Embedded					
Major Service Waiting Periods		Dentcare Delivery Systems, Inc.			
<input type="checkbox"/> None <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months		Account Representative			
TERMS AND CONDITIONS					
<u>DENTAL PLAN INFORMATION</u>					
This plan is underwritten by Dentcare Delivery Systems, Inc. It is understood and agreed that all benefit levels, exclusions and limitations are detailed in the Certificate of Insurance, and the general provisions of this Agreement are detailed in the General Dental Agreement. It is further understood that, upon the applicant signing this application and upon its acceptance by Dentcare Delivery Systems, Inc., the Group Dental Agreement is binding between the applicant and Dentcare Delivery Systems, Inc.					
Application, enrollment cards and payment must be received by the 20th of the month for coverage to begin on the first of the following month. Please make all remittances to: Professional Group Plans, Inc., 225 Wireless Boulevard, Suite 200, Hauppauge, NY 11788.					
<u>MINIMUM PARTICIPATION REQUIREMENT</u>					
CapDent and Select: The group agrees to maintain a minimum of two (2) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.					
CapDent Plus and Select Plus: The group agrees to maintain a minimum of three (3) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.					
Comprehensive Voluntary: Groups with ten (10) or more employees may offer multiple options and are not required to select a single option. Groups with less than ten (10) employees must select a single option. Groups with less than three (3) employees may not select the High or High Enhanced Option.					
Omni Plan: Groups selecting the Omni Plan may combine enrollments with a CapDent Plan to reach minimum eligibility. 50% participation of three (3) employees is required. Groups having less than ten (10) employees must submit their most recent NYS-45 form.					
<u>CANCELLATION POLICY</u>					
If dental coverage lapses due to non-payment of premium, it is understood that the group's policy will be terminated in accordance with NYS insurance law.					
<u>RENEWAL CONDITIONS</u>					
The group is aware that this dental plan is an annual policy. Upon renewal, Dentcare Delivery Systems, Inc. reserves the right to change monthly premium rates.					
<u>BROKER/AGENT APPOINTMENT</u>					
The group confirms that the Broker/Agent named on this application is/are the Broker/Agent of record and will adhere to the Protected Health Information (PHI) and Personally Identifiable Information (PII) guidelines applicable to the group's members.					