Underwritten By
DENTCARE DELIVERY SYSTEMS, INC.

EXECUTIVE DENTAL & VISION PLUS

Co- Administered by
Healthplex®

The Dental and Vision Plan Everyone Is Seeing Clearly to Smile About

New York 3-99 Lives

EMPLOYER APPLICATION FOR EXECUTIVE DENTAL COVERAGE

EMPLOYER INFORMATION

Company Name _____

Address _____

City _____State _____Zip_____

Contact Person _____ Phone_____ Fax _____

E-Mail Address _____Nature Of Business _____

Effective Date of Coverage _____/_____/_____ Note***: Effective Date Of Coverage Must Be First Day Of The Month.***

PLAN REQUESTED

Red PLUS Plan ☐	**White PLUS Plan** ☐	**Blue PLUS Plan** ☐
3 Or More Lives Enrolled	**10 Or More Lives Enrolled**	**10 Or More Lives Enrolled**
Deductible $50/$150 Coinsurance 100%/80%/50% Annual Maximum $1,000	Deductible $50/$150 Coinsurance 100%/80%/50% Annual Maximum $1,500	Deductible $50/$150 Coinsurance 100%/80%/50% Annual Maximum $2,000

Note: Deductible Waived For Preventive Care.

OPTIONAL ORTHODONTIA BENEFIT

50% to $1,000 Lifetime Maximum for Children under the Age 19. Add Additional $8.00 to PPO Option Family/Parent-Child Rate Only.

(Available on PPO Option For Groups Enrolling 20 or More Employees Only.)

Note: Select and Managed Care Options Includes Orthodontia on All Size Groups at No Additional Charge.

Include Benefit ☐ Do Not Include Benefit ☐

SELECT OPTION			MANAGED CARE OPTION			PPO OPTION		
Enrolling	Rate	Subtotal	Enrolling	Rate	Subtotal	Enrolling	Rate	Subtotal
Single _____ X _____ = $_____			Single _____ X _____ = $_____			Single ____ X _____ = $_____		
Empl/Spouse _____ X _____ = $_____			Empl/Spouse _____ X _____ = $_____			Empl/Spouse ____ X _____ = $_____		
Parent/Child _____ X _____ = $_____			Parent/Child _____ X _____ = $_____			Parent/Child ____ X _____ = $_____		
Family _____ X _____ = $ _____			Family _____ X _____ = $ _____			Family _____ X _____ = $ _____		
Subtotal CapDent (A) = $ _____			Subtotal Managed Care (B) = $ _____			Subtotal PPO (C) = $ _____		

Combined Premium (A + B + C) =	$ _____
Monthly Billing Fee +	$ **15.00**_____
Total Monthly Premium =	$ _____

MAKE CHECKS PAYABLE TO: EXECUTIVE DENTAL & VISION

EMPLOYER APPLICATION FOR EXECUTIVE DENTAL COVERAGE

IMPORTANT **Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application.**

WAITING PERIOD

New Employees	☐ 0 days	☐ 30 days	☐ 60 days	☐ 90 days	☐ Other _____ Days

Important Note: Coverage For New Hires Begins The First Of The Month Following The Waiting Period

REPLACEMENT COVERAGE

No Coverage Currently In Force ☐	Coverage Currently In Force ☐
There is a 12 Month Waiting Period For Prosthetics, Crowns (And Orthodontia, if Selected) Will Apply For PPO Option: There Are NO Waiting Periods For The CapDent and Managed Care Option.	Waiting Period For Prosthetics, Crowns (And Orthodontia, if Selected) Will Be Waived If Current Plan Covers These Services. Please Provide: Current Bill ☐ Current Benefit Description ☐ **Waiting Period For Prosthetics, Crowns (And Orthodontia, if Selected) Will Apply To PPO Option For New Employees Only.**

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, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF OFFICER	TITLE	DATE
X_____	_____	_____/ _____/ _____

BROKER INFORMATION

Broker of Record_____ General Agent_____

Broker Name _____

Company Name _____

Address _____City _____State _____Zip_____

E-Mail _____Phone (____)_____Fax (____)_____

Social Security # _____ or Tax ID # _____ **Include Copy Of Current License** ☐

IMPORTANT Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application.