DENTCARE
DELIVERY SYSTEMS, INC.
GROUP DENTAL APPLICATION

EMPLOYER INFORMATION

Company Name____________________

Address____________________

City ____________________ State ________ Zip ____________

Contact Person ____________________ Title ____________ Phone ____________

Group Enrollment Census ______ = Single _______ Two Party _____ Family _______ Requested Effective Date ____/ 01 /_______

Has your company ever had dental coverage with Healthplex Insurance Company, Dentcare Delivery Systems, Inc. or International Healthcare Services, Inc.? YES ☐ or NO ☐

PLEASE CHECK BILLING PERIOD: ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY

PLEASE SELECT A PLAN:

_____ **CapDent** - Minimum enrollment of 2 employees.

_____ **CapDent Plus** - Minimum enrollment of 3 employees.

_____ **CapDent Plus Ultra** - Minimum enrollment of 3 employees.

_____ **Omni Plan -** 50% participation with a minimum of 3 employees. Groups under 10 employees must submit their most recent NYS - 45 Form.

_____ **Comprehensive Voluntary** * - Low _________ Medium ________ High _________ High Enhanced __________

* Groups with 10 or more employees may offer multiple plans and need not select a single plan. Groups with less than 10 employees must select a single plan. Groups of less than 3 employees may not select the High or High Enhanced Plan. Groups with one employee must select annual billing.

NOTES:
1. Groups selecting the **OMNI** Plan may combine with another plan to reach the required minimum. If applicable, enter the name of the other plan along with the number of employees enrolling in the plan.

   ____________________ Name of Other Plan ____________ # of Enrollees ____________ Policy # (if current Plan)
2. There is an additional monthly premium of $10.00 for each family member in excess of five (5).
3. Coverage for all dependents ends at age 19, or age 25, if full-time student.
4. Application, enrollment cards and payment must be received by the 15th of the month for coverage to begin on the first of the next month. Exceptions will only be made if the application is received between the 15th and the 25th of the current month and payment is made by direct debit, certified check, money order, credit card or wire transfer.
5. This application is subject to its acceptance in writing by Dentcare Delivery Systems, Inc.

Please make all remittances payable to: ***Dentcare Delivery Systems, Inc.***

SIGNATURE OF OFFICER	TITLE	DATE

BROKER/AGENT: ____________________

COMPANY: ____________________

ADDRESS: ____________________ STATE: ________ ZIP: ____________

PHONE: ____________________ S.S. # /TAX ID #: ____________________

GROUP #:____________________ SALES REP: ____________________

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