



**CAPDENT/CAPDENT PLUS  
GROUP DENTAL APPLICATION**

**ALL NEW JERSEY PLANS UNDERWRITTEN BY INTERNATIONAL HEALTHCARE SERVICES, INC.**

**EMPLOYER INFORMATION**

Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

Group Census \_\_\_ Single \_\_\_ Two Party \_\_\_ Family \_\_\_ Requested Effective Date \_\_\_ / \_\_\_ / \_\_\_

Please Check Which Plan:                    **CAPDENT** \_\_\_\_\_                    **CAPDENT PLUS** \_\_\_\_\_

**BILLING PERIOD (check one)** MONTHLY \_\_\_\_\_ QUARTERLY \_\_\_\_\_ ANNUALLY \_\_\_\_\_

Coverage for dependents on CapDent/CapDent Plus ends at age 19, or 25 if full-time student. The minimum number of enrollees in CapDent Plus is three. **Capdent groups of two or more will be billed monthly, Capdent groups of one will be billed annually.** Payment must be received by the 15th of the month for coverage to begin on the first of the next month. This application is subject to its acceptance in writing by IHS. Note that premiums are due and payable on the 1<sup>st</sup> of each billing cycle. Please include 1<sup>st</sup> month's premium payment (payable to *International Healthcare Services, Inc.*) with this application. Thank You!

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_

**BROKER INFORMATION**

Sales Representative \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (    ) \_\_\_\_\_ Fax (    ) \_\_\_\_\_

Social Security # \_\_\_\_\_ or Tax ID # \_\_\_\_\_

**FOR INTERNAL USE ONLY**

GROUP # \_\_\_\_\_ Actual Effective Date \_\_\_ / **1** / \_\_\_