Employer Application

Group Dental Coverage

Provided by United HealthCare Insurance Company

Company Name:

Address: | City

State: | Zip Code: | Phone Number:

Fax Number: | Contact Name:

E-Mail Address of Contact:

EMPLOYER INFORMATION

Organization Type: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Political Subdivision[1] ☐ Other

[1]Submit legal opinion or minutes from Board Meeting along with application showing consent.

Full Legal Name of Employer:
Include names of subsidiaries or affiliated companies

Employer Identification Number (Tax ID): | Subject to ERISA? ☐ Yes ☐ No

Has your firm ever filed for or is it in the process of filing for bankruptcy? ☐ Yes ☐ No

DENTAL PLAN PARTICIPATION AND SELECTION

Did the group have dental coverage for the past [12] months? ☐ Yes ☐ No | If yes, name of prior dental carrier:

Requested effective date of coverage: ____/ ____/ _______ All effective dates must be first of the month.

Total number of employees on payroll: | Total number of full time/eligible employees (EE):

Multi Site: ☐ Yes ☐ No | Number of Locations: | Locations:

Number of COBRA participants in total group: | Number of Retirees in total group:

Dental Plan Selected:

Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

Amount of Binder Check:
***This check must accompany the group application.

BILLING AND CONTACT INFORMATION

Please provide the information below if different than above for billing purposes and plan administration.

Address		
City:	State:	Zip Code:
Contact Name:	Phone:	
Fax:	E-Mail Address:	

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of [31] days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the group policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage.

I agree that the company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

Authorized Officer’s Name:	Title:
Authorized Officer’s Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date:
Agent Number:	

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.