



23291 Mill Creek Drive #100 Laguna Hills CA 92653 ♦ Phone (949) 830-1600 Toll-Free (877) 4-DENTAL (433-6825) ♦ Fax (949) 830-1655

www.caldental.net e-mail rfps@caldental.net

GROUP APPLICATION

GROUP INFORMATION

GROUP NAME _____

BILLING ADDRESS _____
STREET ADDRESS SUITE NUMBER CITY STATE ZIP CODE

BILLING CONTACT _____
(Name) (Title) (Email Address) (Phone & Fax)

MAILING ADDRESS (IF DIFFERENT THAN ABOVE) _____
STREET ADDRESS SUITE NUMBER CITY STATE ZIP CODE

DEPENDENT AGE: (SELECT) TO AGE: 26 _____ ID CARDS: (SELECT) TO EMPLOYER _____ TO EMPLOYEE HOMES _____

TYPE OF ENTITY: _____ CORPORATION _____ PARTNERSHIP _____ SOLE PROPRIETORSHIP _____ ASSOCIATION
 _____ OTHER (PLEASE SPECIFY) _____

NATURE OF BUSINESS _____

IS THIS PLAN INTENDED TO REPLACE EXISTING COVERAGE? _____ Yes _____ No WAITING PERIOD? _____ 30DAYS _____ 60 DAYS _____ 90DAYS
(FIRST OF THE MONTH FOLLOWING)

IF SO, WHAT TYPE? _____ HMO _____ INDEMNITY _____ PPO LIMITS _____

PRESENT CARRIER _____
NAME POLICY NUMBER EFFECTIVE DATE OF COVERAGE TERMINATION DATE

PLEASE INCLUDE A COPY OF THE PRIOR CARRIER'S BENEFIT BOOKLET AND A COPY OF THE LAST BILLING.

NUMBER OF ELIGIBLE EMPLOYEES/MEMBERS _____ NUMBER OF ELIGIBLE DEPENDENTS _____

IF ALL EMPLOYEES/MEMBERS ARE NOT ELIGIBLE, PLEASE EXPLAIN _____

EMPLOYER CONTRIBUTION: _____ % EMPLOYEE _____ % DEPENDENT

IF ENROLLMENT IS NOT VOLUNTARY, PLEASE INCLUDE A FORM DE-9, QUARTERLY WAGE & WITHHOLDING REPORT.

PLAN INFORMATION

SELECT PREPAID PLAN:

	<u>3 TIER RATES</u>	<u># ENROLLED</u>	<u>TOTALS</u>	<u>4 TIER RATES</u>	<u># ENROLLED</u>	<u>TOTALS</u>
A75 _____	EO \$ _____ x _____ = \$ _____			EMPLOYEE ONLY \$ _____ x _____ = \$ _____		
A100 _____	+1 \$ _____ x _____ = \$ _____			E + SPOUSE \$ _____ x _____ = \$ _____		
A150 _____	+2 \$ _____ x _____ = \$ _____			E + CHILD(REN) \$ _____ x _____ = \$ _____		
A200 _____				E + FAM \$ _____ x _____ = \$ _____		
A250 _____ OTHER _____						
MONTHLY PREMIUM TOTAL \$ _____						
MONTHLY BILLING/ADMINISTRATION FEE (<i>APPLIES ONLY TO GROUPS ENROLLING LESS THAN 25 ON CDN DHMO</i>) \$ 10.00						
TOTAL FIRST MONTH'S REMITTANCE (PLEASE MAKE CHECKS PAYABLE TO CALIFORNIA DENTAL NETWORK) \$ _____						

SIGNATURES

The above coverage is hereby requested with an effective date of _____.

Employer _____ Date _____
Authorized Representative or Corporate Officer

Writing Agent _____ Tax ID# (or) Agent # _____ Date _____

Sales Representative _____ Date _____