

Company Name		Tax ID #		Effective Date	
Mailing Address		City		State	Zip
Contact Name	Contact Phone #	Fax #		E-mail Address	
Billing Address		City		State	Zip

AGENT INFORMATION

Name	Tax ID #	License #	Phone #
Address			Fax #
Prior Carrier Name	Address		Phone #

DENTAL COVERAGE

Plan Type

Maximum Benefit: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Table of Allowance description: _____	Prior Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No Which Carrier? _____	Non- Member UCR 80%
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Class	Benefit			Waiting Period	Rates		Other	
	Member %	Non-member %			Employee		Office Visit Charge	
Class I				None			Member: none	Nonmember: none
Class II				None	Employee + Spouse		Member: none	Nonmember: \$50
Class IIC				12 Months	Employee + Children		Deductible Applies <input type="checkbox"/> To All Services for Non-Member Dentists	
Class III				12 Months	Family		Policy Year Benefit	

Eligibility

Employees must work _____ hours per week to be eligible on the first month following _____ days of employment.

PARTICIPATION

Total Number of Employees	Total Number of Dependents
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I hereby certify that all employees are enrolling in a selected Group Policy and that all enrolling employees meet the eligibility requirements specified above. I hereby acknowledge receipt of the Outline of Coverage Form. In addition, the group appoints the above agent as our Agent of Records to represent us in matters of group dental benefits provided by Advantage Dental Plan, Inc.

Authorized Signature for Group _____ Date: / /

Authorized Agent Signature: _____ Date: / /