



VOLUNTARY DENTAL APPLICATION FOR EMPLOYER COVERAGE

This application is made by _____ (“Group”) to Blue Cross of Idaho Health Service, Inc., 3000 E. Pine Avenue, Meridian, Idaho 83642 or P.O. Box 7408, Boise, Idaho 83707 (“Blue Cross of Idaho”) for dental insurance coverage (“Group Policy”), the terms of which are hereby approved and accepted by the Group, to take effect on the Policy Date to be specified by Blue Cross of Idaho if this application is approved.

1. The Group represents that it meets the definition of a Small or Medium/Large Employer as set forth in the Group Policy.
2. The Group certifies that the Group is not contributing to any other group or individual dental program that an employer or dependent may be participating in. At the time of this application, the Group represents that it has:
 - A. Total number of employees, including active owners: _____
 - B. Number of employees applying for enrollment under this Contract: _____
3. Eligible employees include:
 - A. Employees working 20 or more hours per week (for groups with at least three (3) active enrollees *and by agreement between Blue Cross of Idaho and the Group*) Yes No (*select A or B*)
 - OR
 - B. Employees working thirty (30) or more hours per week Yes No
 - C. Public officers and public employees (city or county employees only) regardless of the number of hours worked (**applies to small group only**) Yes No
4. The employer may contribute toward the monthly premium rate for employees and dependents. If the employer does contribute, the contribution amounts are as follows:
\$ _____ or _____% per employee and/or \$ _____ or _____% per dependent.
5. The probationary period to be served by new employees: _____ days (*cannot exceed 365 days*). If the probationary period varies by class of employee, please explain: _____

6. **If group is applying for, or already has a medical policy, eligibility requirements must match the medical policy.** Unless required by state or federal law or unless agreed to in writing by Blue Cross of Idaho, the Group agrees not to offer to its employees any other dental coverage that is not provided by or through Blue Cross of Idaho. If the Group violates this provision, Blue Cross of Idaho, at its sole option and upon 30 days written notice to the Group, may recalculate the required premiums for the Group’s insureds, which the Group must thereafter timely pay to maintain coverage under this Policy. Blue Cross of Idaho reserves the right to recertify with the Group, on an annual basis, that Blue Cross of Idaho is the group’s sole health insurance carrier.

It is agreed this application supersedes any previous Blue Cross of Idaho applications.

Name of Group: _____ By: _____
(authorized signature for the Group)

Group Number: _____ By: _____
(print name)

Date: _____ Title: _____