



New Group Questionnaire

Large Groups
Willamette Dental of Idaho, Inc.
Toll Free: (888) 552-0922
Fax: (208) 672-1581

Please print or type and fill in all applicable areas prior to submission.

BROKER INFORMATION

Firm Name: _____

Agent's Full Name: _____

Physical Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____ Email: _____

Firm/Agent License #: _____

Firm/Agency Tax ID #/SSN: _____

Agreed Upon Commission % Being Paid to Broker: _____

Commission to be made with Agency or Individual Agent: _____

GROUP INFORMATION

Full Legal Name: _____

Tax ID#: _____ Affiliates, if any: _____

MAILING ADDRESS (if different from street address on application for group dental coverage)

Street Address/PO Box: _____

City: _____ State: _____ ZIP: _____

SEPARATE LOCATIONS FOR BILLING, IF APPLICABLE: (attach a separate page if more than one)

Street Address/PO Box: _____

City: _____ State: _____ ZIP: _____

INDEMNITY CARRIER, IF ANY

Name: _____

EMPLOYEES

Total Number of Eligible Employees (including full-time & part-time): _____ How Many Employees Are Enrolled? _____

Hours Needed to Be a Full-Time Employee: _____ Effective Date of Coverage: _____

ELIGIBILITY INFORMATION

Billing/Eligibility Contact Name: _____

Phone: _____ Fax: _____ Email: _____

Indicate Monthly Eligibility Transfer (Check One): Hard Copy Electronic

If electronic transfer, please fill out A, B, & C below:

A. Who Will Send Data? (group, broker, TPA) _____

B. What format will data be in? (fixed or variable length) _____

C. How will data be sent? (email, floppy disk, Web) _____

Are any Employees Excluded from the Member Definition? (Check One): YES NO

WAITING PERIOD FOR ELIGIBILITY

Indicate Which Option Applies to Persons Employed on Effective Date (Check One):

Only those who have satisfied the waiting period are eligible. Waiting period for eligibility: _____

All are eligible immediately, regardless of length of service.

ID CARDS

Employer at Initial Billing Directly to Individual Member

PREMIUM PERCENTAGE EMPLOYER CONTRIBUTES

Subscriber: _____ %	Dependents: _____ %	Retirees: _____ %
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Notice of Rate Change Will Be Delivered No Later Than 30 Days Prior to Renewal Date

(Unless otherwise specified): _____

MISCELLANEOUS INFORMATION

- For Trust/Association Groups – please provide copy of current coverage handbook and any applicable bargaining agreements.
- Dependent age is up to age 19 or through 23 if a full-time student unless otherwise requested.

ERISA INFORMATION

Please provide the following information only if the group wishes to include ERISA information in their certificate of coverage.

Plan #: _____

Plan Administrator (if different from group contact information): _____

Registered agent of legal process (if different from group contact information): _____

SPECIAL REQUESTS

Special Requests:
