



DELTA DENTAL & VISION SERVICE PLAN EMPLOYER APPLICATION

EMPLOYER INFORMATION

Company Name		Telephone Number	
Contact Person		Fax Number	
Address	City	State	Zip Code
Billing Address (if different)	City	State	Zip Code
Signature of Company Officer		Date	
Name (print)		Title (print)	

BUSINESS INFORMATION

Date Business Established	SIC Code - REQUIRED
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Partnership Corporation Sole Proprietorship Other: _____

ELIGIBILITY INFORMATION (GROUP MUST HAVE A MINIMUM OF 5 EMPLOYEES TO ENROLL)

EMPLOYEE INFORMATION	DOMESTIC PARTNERS
Total Number of Employees: _____	Are Domestic Partners being allowed on the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Total Number of Eligible Employees: _____	If yes, are you allowing same gender? <input type="checkbox"/> Yes <input type="checkbox"/> No
Total Number Enrolling: _____	Are the children of the D.P. being covered? <input type="checkbox"/> Yes <input type="checkbox"/> No

PROBATIONARY PERIOD

Eligibility begins on the first of the month following 3 months. In order to match medical probationary period, a copy of the employer medical application must be submitted.

Please indicate probationary period if matching medical coverage: Date of Hire¹ 1 Month 2 Months 3 Months Other: _____

¹ First of month following date of hire.

PLAN INFORMATION

DELTAPREMIER & DELTAPREFERRED PLANS	DELTACARE PLANS	VISION SERVICE PLAN																														
Requested Effective Date: _____ <table border="0"> <tr> <td>Employer Contribution:</td> <td>Employee:</td> <td>Choice</td> <td>SBA*</td> </tr> <tr> <td>* SBA Minimum 75%</td> <td></td> <td>100%</td> <td>_____</td> </tr> <tr> <td></td> <td>Dependents:</td> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td>(Minimum 50%)</td> <td></td> <td></td> </tr> </table> <p>Please fill in the number of enrollees applying for each of these plans:</p> <table border="0"> <tr> <td>DeltaPremier</td> <td>DeltaPreferred Option</td> </tr> <tr> <td><input type="checkbox"/> Choice 2000 _____</td> <td><input type="checkbox"/> Choice 2000 _____</td> </tr> <tr> <td><input type="checkbox"/> Choice 1500 _____</td> <td><input type="checkbox"/> Choice 1500 _____</td> </tr> <tr> <td><input type="checkbox"/> SBA 1500 _____</td> <td><input type="checkbox"/> SBA 1500 _____</td> </tr> <tr> <td><input type="checkbox"/> SBA 1000 _____</td> <td><input type="checkbox"/> SBA 1000 _____</td> </tr> <tr> <td><input type="checkbox"/> SBA 50/50/50 1500 _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> SBA 50/50/50 1000 _____</td> <td></td> </tr> </table> <p>Optional Orthodontia¹</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Employer Contribution:	Employee:	Choice	SBA*	* SBA Minimum 75%		100%	_____		Dependents:	_____	_____		(Minimum 50%)			DeltaPremier	DeltaPreferred Option	<input type="checkbox"/> Choice 2000 _____	<input type="checkbox"/> Choice 2000 _____	<input type="checkbox"/> Choice 1500 _____	<input type="checkbox"/> Choice 1500 _____	<input type="checkbox"/> SBA 1500 _____	<input type="checkbox"/> SBA 1500 _____	<input type="checkbox"/> SBA 1000 _____	<input type="checkbox"/> SBA 1000 _____	<input type="checkbox"/> SBA 50/50/50 1500 _____		<input type="checkbox"/> SBA 50/50/50 1000 _____		Requested Effective Date: _____ DeltaCare Choice <input type="checkbox"/> 7S Plan Employer Contribution: Employee: 100% Dependents: _____ (Minimum 50%) DeltaCare SBA <input type="checkbox"/> Plan 512 <input type="checkbox"/> Plan 520 <input type="checkbox"/> Plan 535 Please check the Employer Contribution: <input type="checkbox"/> Option A, Non-Voluntary (at least 75% employer paid) <input type="checkbox"/> Option B, Voluntary (N/A dual choice) (at least 75% employer paid; voluntary for dependents) <input type="checkbox"/> Option C, All-Voluntary (N/A dual choice) (100% employee-paid) ¹ Must be submitted 15 days prior to the effective date. Individual enrollment cards must be submitted for all employees.	Requested Effective Date: _____ Monthly Administration Fee: \$15.00 Employer Contribution: Employee: 100% Dependents: _____ Please fill in the number of enrollees applying for each plan: <input type="checkbox"/> Plan A _____ <input type="checkbox"/> Plan B _____ <input type="checkbox"/> Plan C _____
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¹ Optional Dependent Orthodontia is available for Choice groups with 10 or more enrollees; SBA groups with 25 or more enrollees.

Please make checks payable to: CoPower

Please mail check with your new group application to your nearest LISI location.

Last Name, First Name, MI	M/F	Social Security Number	Date of Birth	Date of Hire	Dependent Status		DELTA DENTAL PLAN OF CALIFORNIA								VSP			
					Spouse	# of Children (< age 25)	DeltaPremier (UCR)				DeltaPreferred Option				Plan	Plan	Plan	
							Choice 2000	Choice 1500	SBA 1500	SBA 1000	Choice 2000	Choice 1500	SBA 1500	SBA 1000	A	B	C	
1.					Y	N												
2.					Y	N												
3.					Y	N												
4.					Y	N												
5.					Y	N												
6.					Y	N												
7.					Y	N												
8.					Y	N												
9.					Y	N												
10.					Y	N												
11.					Y	N												
12.					Y	N												
13.					Y	N												
14.					Y	N												
15.					Y	N												
16.					Y	N												
17.					Y	N												
18.					Y	N												
19.					Y	N												
20.					Y	N												

* Dependents must be under the age of 25 years old AND a full time student, otherwise maximum eligible age is 18 years old.

Please Note: If you are applying for any of our DeltaCare products, your employees must fill out separate applications - do not use this form.

PRODUCER'S STATEMENT (This must be completed for commissions to be paid)		
Producer's Signature _____	Date _____	Make Commission Payable to: Producer _____ Agency _____ Multiple Producer Split _____ (If split case please provide additional broker information)
Producer's Name (print) _____	Federal Tax I.D. # or Soc. Sec. # _____	
Company Name _____	Telephone Number _____ Fax Number _____	
Address _____	City _____ State _____ Zip Code _____	

FOR CoPower USE ONLY

Group No. _____ HR Industry Load _____ Effective _____ Rates Effective as of: _____ Underwriter _____