California Dental Employer Group Application

PRINT OR TYPE ALL SECTIONS IN BLACK INK

Requested Effective Date ____________

Dental HMO plans underwritten by Golden West Dental and Vision
All other Dental plans insured by HumanaDental Insurance Company

Group Number ____________

GROUP INFORMATION

Name of Group	Type of Business	Employer ID #	Phone ( ) Fax ( )

Location Address (not a P.O. Box)	City	County	State	Zip

Billing/Mailing Address	City	State	Zip

DBA	Workers' Compensation Carrier

Administrative Contact	E-mail Address	Management Contact	E-mail Address

MULTILOCATION ☐ NO ☐ YES (complete Multilocation form)

ELIGIBILITY

Total Number of Employees on Payroll:_________

Full-time employees working 30 hours or more per week are eligible if employed by YOU. Part-time and seasonal employees are not eligible.

YOU may choose a different hourly requirement of not less than 20 or more than 40. YOUR hourly requirement:_________

Total number of employees working the hours YOU indicated or more:_______ Number of Employees Enrolling:____

Classes of eligible employees to be excluded: ☐ None ☐ Union ☐ Non Union ☐ Hourly ☐ Salary

New Employee Waiting Period: ☐ 0 Days ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other, Specify_____________

New Employee Effective Date Provision: ☐ First of month following waiting period
☐ Immediately following waiting period

On all plans, the employee termination date coincides with the effective date provision.

RETIREE - The retiree class will be considered if YOU have 26 or more employees enrolled for such coverage. Do YOU want Retirees covered for:
Dental ☐ NO ☐ YES Age______ Years of Service_______

Will YOUR employees have access to another carrier's Dental coverage by virtue of their employment with YOU? ☐ NO ☐ YES Name of Carrier(s)
Dental____________________________

COBRA - Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ NO ☐ YES

Name of Applicant	Qualifying Event (ex: termination of employment, divorce, etc.)	Date of Qualifying Event	Date COBRA or State Continuation coverage terminates

Are there any other entities associated with this company that are eligible to file a combined tax return? ☐ NO ☐ YES

Company Name____ Total Employees______________

Company Name____ Total Employees______________

Company Name____ Total Employees______________

EMPLOYER CONTRIBUTION (See Participation Requirements)

	NON-VOLUNTARY DENTAL	VOLUNTARY DENTAL
EMPLOYER CONTRIBUTION?	Employee % Dependent %	N/A
PRIOR GROUP COVERAGE?	☐ NO ☐ YES	☐ NO ☐ YES

Do YOU have prior Ortho coverage? ☐ NO ☐ YES	For any prior coverage, submit term date and recent billing statement.

DENTAL BENEFIT PLAN OPTIONS

To complete this information, refer to your proposal.

Plan 1	**Plan 2**
Plan name: (as shown on your proposal)	Plan name: (as shown on your proposal)
Deductible: $	Deductible: $
Annual Maximum: $	Annual Maximum: $
Preventive services deductible options: ☐ apply deductible ☐ waive deductible	Preventive services deductible options: ☐ apply deductible ☐ waive deductible
Periodontic/endodontic options: ☐ basic ☐ major	Periodontic/endodontic options: ☐ basic ☐ major

Orthodontia options: ☐ child only: lifetime orthodontia maximum $____________

☐ adult and child: lifetime orthodontia maximum $____________

SPECIAL STATE OPTION FOR CALIFORNIA

YOU may offer coverage to Domestic Partners of YOUR employees. The Domestic Partner can be the same sex or the opposite sex of the employee.

☐ I wish to offer Domestic Partner coverage to my employees.

*CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

THE FOLLOWING APPLIES TO DENTAL HMO PRODUCTS UNDERWRITTEN BY GOLDEN WEST DENTAL AND VISION (GWDV)

YOU, the Policyholder, intend to establish, sponsor, and endorse an Employee Benefit Plan which will be governed by the Employee Retirement Income Security Act of 1974 (ERISA). YOU are the ERISA Plan Administrator.

Dental Health Maintenance Organization is a unique joint venture between HumanaDental Insurance Company and Golden West Dental and Vision (GWDV) designed to build high quality, cost effective Dental care delivery. Under this agreement, the two companies are partners in a marketing and administration agreement.

With respect to paying claims for benefits or determining eligibility for coverage under this Policy or Group Plan, HumanaDental Insurance Company or GWDV shall have full and exclusive discretionary authority to: 1) interpret Policy provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

THE FOLLOWING APPLIES TO ALL PRODUCTS INSURED BY HUMANADENTAL INSURANCE COMPANY

YOU, the Participating Employer, Policyholder, Contractholder, or Group Plan Sponsor, intend to establish, sponsor, and endorse an Employee Benefit plan which will be governed by the Employee Retirement Income Security Act of 1974 (ERISA). YOU are the ERISA Plan Administrator.

YOU agree to make available YOUR records which WE determine are relevant to this Application and group coverage for inspection by the Trustee, Administrator, US or OUR representative during YOUR normal business hours.

With respect to paying claims for benefits or determining eligibility for coverage under this Policy or Group Plan, WE as administrator for claims determinations and as ERISA claims review fiduciary as described in 29 C.F.R. 2560.503-1(g)(2), shall have full and exclusive discretionary authority to: 1) interpret Policy or Group Plan provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

YOU understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by US, following a grace period of 31 days from the date of non-payment of premium. WE may terminate YOUR coverage according to the termination section of the Policy or Group Plan. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, YOU will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by US for non-payment of premium, YOU will still owe and WE will collect all due premium including premium for the grace period.

For YOU to remain eligible for the Policy or Group Plan, the eligibility, Underwriting and Participation Requirements must be maintained, for all coverage. Failure to maintain the plan eligibility, Underwriting and Participation Requirements will terminate YOUR coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan.

Based upon OUR standard underwriting practice WE may require an employee or dependent to submit Evidence of Health Status. WE have the right to use the information provided by YOU and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums.

UNDERWRITING AND PARTICIPATION REQUIREMENTS

YOU must have the greater of 5 employee lives or as indicated by coverage. Failure to maintain participation requirements will result in termination of that coverage.

DENTAL

YOU may not sponsor a Dental plan from a carrier other than US. All Dental coverage may be terminated if YOU offer other Dental coverage from a carrier other than US. WE will deem YOU to be offering such coverage if employees have access to another carrier's Dental coverage by virtue of their employment with YOU.

Non-Voluntary

1. If YOU elect this coverage and pay 100% of the premium, YOU must have 100% participation of all eligible employees, regardless of whether they have Dental coverage through their spouse.
2. If YOU elect this coverage and YOU pay less than 100% of the premium, YOU must have the following participation of eligible employees:

Eligible Employees:	5 - 9	10+
Participation Requirements:	75%	75% (50% with spousal waiver)

3. YOU are required to contribute at least 25% of the premium for each employee benefit.
4. If YOU elect this coverage, YOU must have a minimum of 5 eligible employees participating.

Voluntary - Traditional Preferred and PPO

1. If YOU elect this coverage, YOU must have the following participation of eligible employees regardless if they have Dental coverage through their spouse.

Eligible Employees:	5+
Participation Requirements:	greater of 5 or 25%

2. No employer contribution is required.
3. If YOU elect this coverage, YOU must have a minimum of 5 eligible employees participating.

Voluntary - Dental HMO

If YOU elect this coverage, YOU must have a minimum of 5 eligible employees participating.

EMPLOYER AGREEMENT

YOU, the employer, understand and agree that the first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on the Application. YOU agree to collect any employee contribution toward premium. If this Application is declined, WE will return the premium deposit submitted with the Application. YOU understand and agree that neither YOU nor the agent has the authority to waive a complete answer to any question, pass on coverage, alter any contract, or waive any of OUR other rights or requirements. YOU hereby certify that YOU have read this document and that the information provided is accurate and complete. YOU also certify that the information provided here can be substantiated by business records maintained by YOU. YOU agree to provide the documentation requested by US which establishes that all eligibility, underwriting and participation requirements of the Group Plan are met. YOU understand and agree that only individuals who meet the eligibility requirements of the Group Plan are entitled to maintain coverage. YOU understand that providing incomplete, inaccurate, or untimely information may void, reduce, or terminate an individual's coverage or the group's coverage. This document will form part of any contract issued. Coverage is not in effect unless and until YOU receive written notification from US. **UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL BY US.**

DATED ON:________________________ (Month, Day, Year)

BY: X____ (Employer signature)

DATED AT:________________________ (City and State)

____ (Title)

AGENT INFORMATION

1. AGENT/AGENCY OF RECORD (Commissions/Correspondence)

Social Security/Tax ID No.____________________________________

Name____________________________________

Street____________________________________

City____________ State__________ Zip__________

Phone No.__________ Fax No.__________________

Commission Split_____ % (Required for split commissions, total % should = 100)

WRITING AGENT (Agent who actually solicited the case)

Name____________________________________

Street____________________________________

City____________ State__________ Zip__________

Phone No.__________ Fax No.__________________

Social Security Number____________________________________

Agent E-Mail Address____________________________________

2. AGENT/AGENCY OF RECORD (For Split Commissions)

Social Security/Tax ID No.____________________________________

Name____________________________________

Street____________________________________

City____________ State__________ Zip__________

Phone No.__________ Fax No.__________________

Commission Split % (Required for split commissions, total % should = 100)

As the Writing Agent, I acknowledge that I am responsible to meet with the Employer submitting this application in order to fully and accurately represent the terms and conditions of the products and services of the offering entity, Humana, or one of its subsidiaries. These provisions are available to me and the Employer in the Regulatory and Technical Information Guide or other Humana marketing material.

Writing Agent's Signature____________________________________

Date____________________________