

# Small Group Employer Agreement and Application



Sales Department LC05-206  
3110 Lake Center Drive  
Santa Ana, CA 92704  
Fax 714-513-6381  
800-516-4680

Group Number		Dental Indem	Dental PPO	Vision PPO																																												
Employer			Employer Tax I.D. Number																																													
Address		City	County	State	Zip																																											
Billing address (if different from above)			Type of business																																													
Phone number	Fax number	Email address		Requested effective date																																												
Name and title of person to whom billing is directed			No. of years in same location	No. of years in business																																												
Minimum premium contribution by employer: 50% of the employee's premium or 50% of the employee's and the dependent's combined premium. Employee _____%    Dependent _____%		<b>WAITING PERIOD FOR ELIGIBLE EMPLOYEES</b> – New employees are eligible for coverage on the first of the month after satisfying one of the following employee waiting periods. <input type="checkbox"/> First of the month following date of hire <input type="checkbox"/> First of the month following introductory period of 30/60/90 days. (circle one) <input type="checkbox"/> Other (please specify): _____																																														
Will this replace any existing insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, name of previous carrier (include copy of billing & policy)																																															
No. of years with previous carrier	Date of termination	No. of eligible employees	No. of employees applying for coverage																																													
Is employer required to offer COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, list number of participants																																														
<b>PACIFICARE DENTAL PPO PLAN OPTIONS<sup>1</sup></b>  <b>PLAN</b> <input type="checkbox"/> Plan II <input type="checkbox"/> Plan VII <input type="checkbox"/> Other 100/80        100/70        ___/___ 80/50        NA              ___/___ 50/50        NA              ___/___  <b>VOLUNTARY PLAN</b> <input type="checkbox"/> Plan IIA <input type="checkbox"/> Plan VII <input type="checkbox"/> Plan IIB  <b>MAX COVERAGE</b> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Other _____  <b>DEDUCTIBLE</b> <input type="checkbox"/> \$50 Individual/\$150 Family In-Network, \$100 Individual/\$300 Family Out-of-Network <input type="checkbox"/> Other _____  <b>REIMBURSEMENT</b> <input checked="" type="checkbox"/> Fee Schedule _____  <input type="checkbox"/> <b>COST MANAGEMENT OPTION</b> – Endodontic, Periodontic & Oral Surgery covered in Major Services (Required for voluntary plans)		<b>PACIFICARE DENTAL INDEMNITY PLAN OPTIONS<sup>1</sup></b>  <b>PLAN</b> <input type="checkbox"/> Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> Other _____ 80/80/50        100/80/50  <b>MAX COVERAGE</b> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Other _____  <b>DEDUCTIBLE</b> <input type="checkbox"/> \$50 Individual/\$150 Family <input type="checkbox"/> Other _____  <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">4-TIER</th> <th style="text-align: left;">RATE</th> <th style="text-align: left;"># ENROLLED</th> <th style="text-align: left;">TOTAL</th> </tr> </thead> <tbody> <tr> <td>EE</td> <td>\$ _____ x _____</td> <td>=</td> <td>\$ _____</td> </tr> <tr> <td>EE + Spouse</td> <td>\$ _____ x _____</td> <td>=</td> <td>\$ _____</td> </tr> <tr> <td>EE + Child(ren)<sup>2</sup></td> <td>\$ _____ x _____</td> <td>=</td> <td>\$ _____</td> </tr> <tr> <td>Family</td> <td>\$ _____ x _____</td> <td>=</td> <td>\$ _____</td> </tr> <tr> <td colspan="4" style="text-align: right;">Total Dental Indemnity Monthly Premium = \$ _____</td> </tr> </tbody> </table>			4-TIER	RATE	# ENROLLED	TOTAL	EE	\$ _____ x _____	=	\$ _____	EE + Spouse	\$ _____ x _____	=	\$ _____	EE + Child(ren) <sup>2</sup>	\$ _____ x _____	=	\$ _____	Family	\$ _____ x _____	=	\$ _____	Total Dental Indemnity Monthly Premium = \$ _____																							
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Total Combined Monthly Premium            \$ _____		SEE OTHER SIDE FOR AGREEMENT																																														
First Month's Remittance                        \$ _____		Make checks payable to: <b>PACIFICARE DENTAL &amp; VISION ADMINISTRATORS</b>																																														

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWINGLY THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

1. I understand that only regular, full time, active employees, partners and proprietors, working a minimum of 20 hours per week and their eligible dependents are eligible for coverage. I understand the pre-existing conditions limitations of the insurance plan, and understand that coverage is renewable at the option of the Underwriting Company.
2. I understand the underwriting and participation requirements, and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The open enrollment period shall be during group 's 11th month of annual continuous coverage.
3. The Employer Agreement and Application, the first month's premium check, and employee information must be received in our office no later than the 25th of the month prior to the requested effective date. Insurance coverage shall become effective on the first day of the following month. All employees will be billed monthly with premiums due by the last day of the month preceding coverage.
4. Enrollment applications for new hires must be received by the last day of the month in order to reflect on the next month's billing invoice.
5. **For the PacifiCare Indemnity and PPO dental plans, I understand that there is a one year waiting period for "Major" dental services. Depending on the group's plan, "Major" dental services include either crowns, dentures and bridges OR crowns, dentures, bridges, oral surgery, periodontics and endodontics. This waiting period will be waived for employees/dependents listed on the prior carrier's billing at the time of transfer to a PacifiCare Indemnity or PPO dental plan. New hires are subject to a one-year waiting period for all "Major" dental services.**
6. Employers will not be eligible to participate in the plan if the number of eligible employees drops below two. A notice of termination will be sent to the employer unless the plan receives notification that another employee has been hired before the next premium due date.
7. The PPO and Indemnity Dental, and Vision plans are underwritten by PacifiCare Life Assurance Company.

Signature of authorized person \_\_\_\_\_ Date signed \_\_\_\_\_

Print name of authorized person \_\_\_\_\_ Title \_\_\_\_\_

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge, I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Broker or General Agent signature \_\_\_\_\_ Date \_\_\_\_\_

Print name of Broker or General Agent \_\_\_\_\_ Agent # \_\_\_\_\_

Address (street, city, state, zip) \_\_\_\_\_ Phone # \_\_\_\_\_

E-mail address \_\_\_\_\_ Fax # \_\_\_\_\_