

GROUP MASTER APPLICATION

Please check: New Case Change to Existing Coverage Add Additional Dental or Vision Plan Change in Employer Information

Group Number (if existing case): _____

1. Requested Effective Date

I request that the coverage(s) chosen take effect on: _____ 20 _____.
Note: Actual effective date will be assigned once application is approved.

2. Employer Information

1. Company Name: _____

2. Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Billing Address (if different from above): _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

3. Group Contact: _____ Phone: (____) _____ Fax: (____) _____

4. Billing Contact: _____ Phone: (____) _____ Fax: _____

5. Applicant is a: Corporation Partnership Sole Proprietorship Union Other _____

6. Nature of Business: _____ SIC Code: _____

8. Do you wish to have billings separated for different locations/departments? Yes No
If yes, please attach census for each location/department and billing instructions.

9. Is this plan intended to replace any existing group dental coverage? Yes No
If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of Plan (HMO, PPO, Indemnity)	Effective Date	Proposed Termination Date
_____	_____	_____	_____
_____	_____	_____	_____

3. Employer Contribution

Non-Voluntary Plan Options

Stand-alone Dental or Vision Plans: Employer must contribute a minimum of 50% of employee's monthly premium.
Dual Option (HMO/PPO Dental): Employer must contribute a minimum of 75% of employee's monthly HMO premium with same dollar amount contributed to employee's monthly PPO premium. Employee buys up to PPO plan.

Employer contribution: _____% Employee monthly premium _____% Dependent monthly premium

If employer contribution is a fixed dollar amount as part of a Flexible Benefit Program under Section 125, indicate dollar amount contributed to employee's monthly premium: \$ _____

Note: If employer contributes 100% of employee premium, then 100% of eligible employees must enroll.

Voluntary Plan Options

Stand-alone Dental or Vision Plans: Employer contributes 0-49% of employee's monthly premium.
Dual Option (HMO/PPO Dental): Employer contributes 0-74% of employee's monthly premium.

Employer contribution: _____% Employee monthly premium

4. Employee Eligibility

1. Total number of employees (including owners/officers): _____

2. Number of eligible full-time (minimum 30 hours per week) employees including owners/officers (minimum 20 hours per week): _____

3. Are all eligible employees subject to withholding as on a W-2 form? Yes No
 If no, please explain: _____

4. Total number of eligible ENROLLING employees including COBRA/Cal-COBRA applicants: _____

5. Number of eligible employees DECLINING coverage: _____

6. Number of ineligible employees: _____ Reason for ineligibility: _____

7. If plan(s) offered is a class carve-out (i.e. management only), please identify the class of employees to be covered: _____
 _____ Which plan(s): _____

8. Each newly hired employee's effective date will be the first day of the month following the completion of the group eligibility period. Indicate eligibility/probationary period for future employees:
 First day of the month following date of hire 1 month 2 months 3 months 6 months Other: _____

9. Is your group currently subject to Cal-COBRA? (employed 2-19 full-time employees on at least 50% of the working days in the previous calendar year) Yes No **If you answered Yes to #10 or #11 please complete Section 5.**

10. Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year and are not subject to Cal-COBRA) Yes No

5. COBRA/Cal-COBRA Questionnaire

A. Complete for each employee or family member currently on COBRA or Cal-COBRA			
1. Name	Date of Birth	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	Social Security #
Date of Qualifying Event	Qualifying Event		
2. Name	Date of Birth	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	Social Security #
Date of Qualifying Event	Qualifying Event		
3. Name	Date of Birth	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	Social Security #
Date of Qualifying Event	Qualifying Event		
B. For COBRA Applicants: Complete for each employee terminated in the last 90 days who has experienced a qualifying event. For Cal-COBRA Applicants: Complete for each employee terminated in the last 60 days who has experienced a qualifying event.			
1. Name	Date of Termination	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	Social Security #
Qualifying Event			
To the best of your knowledge, will this employee/dependent exercise their COBRA/Cal-COBRA option?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, is this employee/dependent presently disabled?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, disabling condition: _____			
2. Name	Date of Termination	<input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	Social Security #
Qualifying Event			
To the best of your knowledge, will this employee/dependent exercise their COBRA/Cal-COBRA option?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, is this employee/dependent presently disabled?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, disabling condition: _____			

If additional space is needed to include all applicable employees, you may list the information on a photocopy of this page and submit it with your application.

6. Coverage Requested

Non-Voluntary and Voluntary HMO Dental & Vision Plans		
Dental	Include at No Charge:	Options
<input type="checkbox"/> 89L1 <input type="checkbox"/> Preferred Choice <input type="checkbox"/> SmileChoice 100 <input type="checkbox"/> 89L2 <input type="checkbox"/> Premier Advantage <input type="checkbox"/> SmileChoice 200 <input type="checkbox"/> 89L3 <input type="checkbox"/> 89L1-2-3 <input type="checkbox"/> 89L2-3	<input type="checkbox"/> Orthodontia Plan 4 <input type="checkbox"/> Vision Plan 89E	<input type="checkbox"/> Cosmetic Benefit Rider
Stand-Alone Vision		
<input type="checkbox"/> 90GE <input type="checkbox"/> Vision Advantage		

Non-Voluntary Dental PPO Plans							
Plan Type	In Network	Out of Network	Calendar Yr Maximum	Deductible	Waive Deduct. for Preventive	Endo/Perio	PPO Orthodontia
<input type="checkbox"/> Select <input type="checkbox"/> Standard	<input type="checkbox"/> 100/100/60 <input type="checkbox"/> 100/90/60 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> Other ___/___/___	<input type="checkbox"/> 100/80/50 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> 90/70/50 <input type="checkbox"/> 100/80/50 <input type="checkbox"/> 80/80/50 <input type="checkbox"/> Other ___/___/___	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$3000	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100	<input type="checkbox"/> In Network Only <input type="checkbox"/> In & Out of Network	<input type="checkbox"/> Basic <input type="checkbox"/> Major	<input type="checkbox"/> PPO 50% to \$1000 <input type="checkbox"/> PPO 50% to \$1500 <input type="checkbox"/> PPO 50% to \$2000 Ortho coverage for: <input type="checkbox"/> Child Only <input type="checkbox"/> Adults/Children
	Do you wish to include HMO Vision Plan 89E and HMO Orthodontia Plan 4 at no additional charge? (Covers CA residents only) <input type="checkbox"/> Yes <input type="checkbox"/> No						

Voluntary Dental PPO Plans						
In Network	Out of Network	Calendar Yr Maximum	Deductible	Waive Deduct. for Preventive	Endo/Perio	PPO Orthodontia
<input type="checkbox"/> 100/80/50 <input type="checkbox"/> Other ___/___/___	<input type="checkbox"/> 90/70/50 <input type="checkbox"/> Other ___/___/___	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500	<input type="checkbox"/> \$50 <input type="checkbox"/> \$_____	<input type="checkbox"/> In Network Only <input type="checkbox"/> In & Out of Network	<input type="checkbox"/> Basic <input type="checkbox"/> Major	<input type="checkbox"/> PPO 50% to \$1000 <input type="checkbox"/> PPO 50% to \$1500 Ortho coverage for: <input type="checkbox"/> Child Only <input type="checkbox"/> Adults/Children
Do you wish to include HMO Vision Plan 89E and HMO Orthodontia Plan 4 at no additional charge? (Covers CA residents only) <input type="checkbox"/> Yes <input type="checkbox"/> No						

Please note: Underwriting will determine final rates based on actual enrollment, contribution levels, participation, and the effective date of coverage.

7. Signature

Check the box that applies:

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employment Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employment Retirement Income Security Act of 1974), and therefore not subject to ERISA, apply to obtain the coverage indicated.

If we are enrolled as an administrator of an Employee Welfare Benefit Plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq) we understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, we further understand that any dispute we may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process has been completed.

To the best of our knowledge and belief, all information on this application is true and complete, and Golden West Dental & Vision may rely on this application in deciding whether to provide coverage. If the application is not complete, Golden West reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Golden West and only if we have paid our first month's contribution and this application is accepted. We understand that no agent or broker has the right to approve this application or bind coverage. If this application is accepted, it becomes a part of our contract with Golden West Dental & Vision. Coverage may be rescinded if there are misstatements in this application.

NAME OF COMPANY OFFICER (PLEASE PRINT)

TITLE OF COMPANY OFFICER

X

SIGNATURE OF COMPANY OFFICER

DATE (Month/Day/Year)

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erase information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification.

8. Agent's Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.

WRITING AGENT

Agent #	Tax ID#/SS #	% Commissions split with second agent	
Name <i>as licensed</i>		License #	
Street Address		City/State/Zip	
Phone	Fax	E-Mail	
Signature		Date	City and State Where Signed

X

SECOND WRITING AGENT

Agent #	Tax ID#/SS #	% Commissions split with writing agent	
Name <i>as licensed</i>		License #	
Street Address		City/State/Zip	
Phone	Fax	E-Mail	
()	()		
Signature		Date	City and State Where Signed

X

GENERAL AGENT

Agent #	Name	Tax ID#/SS#
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Submit application to:
Golden West Dental & Vision
Underwriting Department
PO Box 5347
Oxnard, CA 93031-5347