

NEW BUSINESS GROUP APPLICATION

To ensure fast processing of your application, please complete the information below in its entirety. The purpose of this form is to confirm the level of dental benefits, rates and billing information for your organization. Acceptance of your application is subject to DentaQuest Mid-Atlantic, Inc.'s underwriting guidelines and approval.

EMPLOYER INFORMATION	Group Name: _____
	Physical Address: _____
	Billing Address: _____
	Phone: (____) _____ Fax: (____) _____
	HR Director: _____ E-mail Address: _____
	Day-to-Day Contact: _____ E-mail Address: _____
	Billing Contact: _____ E-mail Address: _____

SELECT A DENTAL PLAN	CHOICE PPO Plan Design	ACCESS PPO Plan Design	ACCESS EPPO Plan Design	SELECT <input type="checkbox"/>
	Type I In _____ % Out _____	Type I In _____ % Out _____	Schedule A <input type="checkbox"/> Schedule C <input type="checkbox"/>	
	Type II In _____ % Out _____	Type II In _____ % Out _____	Deductibles <input type="checkbox"/> \$25/\$75	
	Type III In _____ % Out _____	Type III In _____ % Out _____	<input type="checkbox"/> \$50/\$150	
	Deductibles <input type="checkbox"/> \$50/\$150 or <input type="checkbox"/> \$ _____	Deductibles <input type="checkbox"/> \$50/\$150 or <input type="checkbox"/> \$ _____	Annual Max. <input type="checkbox"/> \$2,000	
	Annual Max. \$ _____ Ortho Max _____	Annual Max. \$ _____ Ortho Max _____	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> MAC <input type="checkbox"/> 80 th UCR <input type="checkbox"/> EPO Basic <input type="checkbox"/> EPO Major	<input type="checkbox"/> EPO Basic <input type="checkbox"/> EPO Major	Special Instructions _____	
	Special Instructions _____	Special Instructions _____		

PARTICIPATION VERIFICATION	<input type="checkbox"/> Contributory \$ _____ or % _____ (employer contribution required)		<input type="checkbox"/> Voluntary (no minimum contribution required)		
	1. Total number of employees: _____	RIDERS			Coverage Period: From: ____/____/____ To: ____/____/____
	2. Number of employees eligible for dental benefits: _____	STANDARD PLAN OTHER			
	3. Number of employees you are enrolling with DentaQuest _____	Children to Age: <input type="checkbox"/> 19 <input type="checkbox"/> _____			
	4. Number of employees waiving benefits due to coverage through a spouse or another reason: (a letter or proof of waiver may be required) _____	Students to Age: <input type="checkbox"/> 23 <input type="checkbox"/> _____			
		Ortho to Age <input type="checkbox"/> 19 <input type="checkbox"/> Any Age			
		Spousal Equivalents <input type="checkbox"/> Yes <input type="checkbox"/> No			
		(Domestic Partners)			

RATE & SUBSCRIBER	CHOICE PPO			ACCESS PPO			ACCESS EPPO A or C			SELECT		
	Rate	Count	Total	Rate	Count	Total	Rate	Count	Total	Rate	Count	Total
Individual	\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____		
Individual + Spouse	\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____		
Individual + Child	\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____		
Family	\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____			\$ _____ X _____ = _____		
Total												

BILLING OPTIONS	<input type="checkbox"/> FULLY INSURED	TPA/GA	TPA: _____
	First month's \$ _____ premium due w/ application		GA: _____
	Please add your total columns together to determine this figure		
	<input type="checkbox"/> SELF INSURED		
	<input type="checkbox"/> Administrative Rate _____%		
	<input type="checkbox"/> Per subscriber per \$ _____ month rate		
	Deposit due w/ application \$ _____		

BROKER INFORMATION	BROKER INFORMATION (IF APPLICABLE)	EMPLOYER SIGNATURE	I HEREBY APPLY FOR THE DENTAQUEST MID-ATLANTIC, INC. PLAN AS OUTLINED ABOVE AND I DESIGNATE THE BROKER NAMED ON THIS FORM (IF APPLICABLE) HEREON TO ACT ON OUR ORGANIZATION'S BEHALF.
	Broker Name: _____		Company Representative Signature: _____
	Firm: _____		Print Name: _____
	Address: _____		Title: _____
	City: _____ State: _____ Zip: _____		Date: _____
	Phone: (____) _____ Fax: (____) _____		Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
	E-mail address: _____ Broker Signature: _____		

DENTAQUEST MID-ATLANTIC, INC. INTERNAL USE ONLY		
Underwriting Approval: _____	Group Number Assigned: _____	Additional Sub-locations: _____