DentaQuest
VIRGINIA, INC

ATTN: SALES DEPARTMENT
4061 POWDER MILL ROAD
SUITE 325
CALVERTON, MD 20705
TEL: 1-800-879-0288
FAX: (301) 937-0245

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 Virginia, Inc.'s underwriting guidelines and approval.

EMPLOYER INFORMATION

Group Name: ______
Physical Address: ______
Billing Adress: ______
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	ACCESS PPO	ACCESS EPPO	SELECT
Plan Design	Plan Design	Plan Design	☐
Type I In ___ % Out ___	Type I In ___ % Out ___	Schedule A ☐ Schedule C ☐	
Type II In ___ % Out ___	Type II In ___ % Out ___	Deductibles ☐ $25/$75	
Type III In ___ % Out ___	Type III In ___ % Out ___	☐ $50/$150	
Deductibles ☐ $50/$150 or ☐ $___	Deductibles ☐ $50/$150 or ☐ $___	Annual Max. ☐ $2,000	
Annual Max. $___ Ortho Max___	Annual Max. $___ Ortho Max___	☐ Other___	
☐MAC ☐80th UCR ☐EPO Basic ☐EPO Major	☐EPO Basic ☐EPO Major	Special Instructions ___	
Special Instructions ___	Special Instructions ___		

PARTICIPATION VERIFICATION

☐ Contributory $______ or % ______ (employer contribution required) ☐ Voluntary (no minimum contribution required)

1. Total number of employees: ______
2. Number of employees eligible for dental benefits: ______
3. Number of employees you are enrolling with DentaQuest ______
4. Number of employees waiving benefits due to coverage through a spouse or another reason: (a letter or proof of waiver may be required) ______

RIDERS

	STANDARD PLAN	OTHER
Children to Age:	☐ 19	☐ ______
Students to Age:	☐ 23	☐ ______
Ortho to Age	☐ 19	☐ Any Age
Spousal Equivalents (Domestic Partners)	☐ Yes	☐ No

Coverage Period:
From: ___/___/___
To: ___/___/___

RATE & SUBSCRIBER

	CHOICE PPO Rate	Count	Total	ACCESS PPO Rate	Count	Total	ACCESS EPPO A or C Rate	Count	Total	SELECT 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

☐ FULLY INSURED
First month's $ ______
premium due w/ application
Please add your total columns together to determine this figure

☐ SELF INSURED
☐ Administrative Rate ______%
☐ Per subscriber per month rate $ ______
Deposit due w/ application $ ______

TPA / GA

TPA: ______
______
GA: ______
______

BROKER INFORMATION

BROKER INFORMATION (IF APPLICABLE)

Broker Name: ______
Firm: ______
Address: ______
City: ______ State: ______ Zip: ______
Phone: ( ) ______ Fax: ( ) ______
E-mail address: ______
Broker Signature: ______

EMPLOYER SIGNATURE

I HEREBY APPLY FOR THE DENTAQUEST VIRGINIA, INC. PLAN AS OUTLINED ABOVE AND I DESIGNATE THE BROKER NAMED ON THIS FORM (IF APPLICABLE) HEREON TO ACT ON OUR ORGANIZATION'S BEHALF.

Company Representative Signature: ______
Print Name: ______
Title: ______
Date: ______

DENTAQUEST VIRGINIA, INC. INTERNAL USE ONLY

Underwriting Approval: ______ Group Number Assigned: ______ Additional Sub-locations: ______