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## GROUP APPLICATION

### GROUP INFORMATION

GROUP NAME \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_  
STREET ADDRESS SUITE NUMBER CITY STATE ZIP CODE

BILLING CONTACT \_\_\_\_\_  
(Name) (Title) (Email Address) (Phone & Fax)

MAILING ADDRESS (IF DIFFERENT THAN ABOVE) \_\_\_\_\_  
STREET ADDRESS SUITE NUMBER CITY STATE ZIP CODE

DEPENDENT AGE: (SELECT) TO AGE: 26 \_\_\_\_\_ ID CARDS: (SELECT) TO EMPLOYER \_\_\_\_\_ TO EMPLOYEE HOMES \_\_\_\_\_

TYPE OF ENTITY: \_\_\_\_\_ CORPORATION \_\_\_\_\_ PARTNERSHIP \_\_\_\_\_ SOLE PROPRIETORSHIP \_\_\_\_\_ ASSOCIATION  
 \_\_\_\_\_ OTHER (PLEASE SPECIFY) \_\_\_\_\_

NATURE OF BUSINESS \_\_\_\_\_

IS THIS PLAN INTENDED TO REPLACE EXISTING COVERAGE? \_\_\_\_\_ Yes \_\_\_\_\_ No WAITING PERIOD? \_\_\_\_\_ 30DAYS \_\_\_\_\_ 60 DAYS \_\_\_\_\_ 90DAYS  
(FIRST OF THE MONTH FOLLOWING)

IF SO, WHAT TYPE? \_\_\_\_\_ HMO \_\_\_\_\_ INDEMNITY \_\_\_\_\_ PPO LIMITS \_\_\_\_\_

PRESENT CARRIER \_\_\_\_\_  
NAME POLICY NUMBER EFFECTIVE DATE OF COVERAGE TERMINATION DATE

PLEASE INCLUDE A COPY OF THE PRIOR CARRIER'S BENEFIT BOOKLET AND A COPY OF THE LAST BILLING.

NUMBER OF ELIGIBLE EMPLOYEES/MEMBERS \_\_\_\_\_ NUMBER OF ELIGIBLE DEPENDENTS \_\_\_\_\_

IF ALL EMPLOYEES/MEMBERS ARE NOT ELIGIBLE, PLEASE EXPLAIN \_\_\_\_\_

EMPLOYER CONTRIBUTION: \_\_\_\_\_ % EMPLOYEE \_\_\_\_\_ % DEPENDENT

IF ENROLLMENT IS NOT VOLUNTARY, PLEASE INCLUDE A FORM DE-9, QUARTERLY WAGE & WITHHOLDING REPORT.

### PLAN INFORMATION

**SELECT PREPAID PLAN:**

	<u>3 TIER RATES</u>	<u># ENROLLED</u>	<u>TOTALS</u>	<u>4 TIER RATES</u>	<u># ENROLLED</u>	<u>TOTALS</u>
A75 _____	EO \$ _____ x _____ = \$ _____			EMPLOYEE ONLY \$ _____ x _____ = \$ _____		
A100 _____	+1 \$ _____ x _____ = \$ _____			E + SPOUSE \$ _____ x _____ = \$ _____		
A150 _____	+2 \$ _____ x _____ = \$ _____			E + CHILD(REN) \$ _____ x _____ = \$ _____		
A200 _____				E + FAM \$ _____ x _____ = \$ _____		
A250 _____ OTHER _____						
MONTHLY PREMIUM TOTAL ..... \$ _____						
MONTHLY BILLING/ADMINISTRATION FEE ( <i>APPLIES ONLY TO GROUPS ENROLLING LESS THAN 25 ON CDN DHMO</i> ) ..... \$ <b>10.00</b>						
TOTAL FIRST MONTH'S REMITTANCE (PLEASE MAKE CHECKS PAYABLE TO CALIFORNIA DENTAL NETWORK) ..... \$ _____						

### SIGNATURES

The above coverage is hereby requested with an effective date of \_\_\_\_\_.

Employer \_\_\_\_\_ Date \_\_\_\_\_  
Authorized Representative or Corporate Officer

Writing Agent \_\_\_\_\_ Tax ID# (or) Agent # \_\_\_\_\_ Date \_\_\_\_\_

Sales Representative \_\_\_\_\_ Date \_\_\_\_\_