

Master Dental Contract Application Pooled Programs

PART A – COMPANY INFORMATION:

Legal Company Name _____		
Physical Address _____	Phone () _____	

City _____	State _____	Zip Code _____
Plan Effective Date: _____		
Eligibility probationary period for new employees: First of month following: _____ Other: _____		
Type of Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Dependents		
Does your company currently have a dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (name of carrier) _____		
(Attach copy of most recent billing statement)		Length of coverage: _____

PART B – ELIGIBLE EMPLOYEES:

Total number of eligible employees: _____

PART C – DENTAL PROGRAM (choose one):

<input type="checkbox"/> Prime <input type="checkbox"/> Complete
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PART D – VOLUNTARY PLANS:

<input type="checkbox"/> ANTHEM VOLUNTARY				
Select Plan Design	<input type="checkbox"/> Active	<input type="checkbox"/> Passive	Select Annual Deductible	<input type="checkbox"/> \$25/75 <input type="checkbox"/> \$50/150
Select Annual Maximum	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	Annual Maximum Carryover	<input type="checkbox"/> Yes <input type="checkbox"/> No
Select Orthodontic Coverage (A minimum of 10 employees must enroll)				
<input type="checkbox"/> 50% coverage for dependent children; Lifetime maximum to match annual maximum.				
<input type="checkbox"/> No Coverage				
Participation: A minimum of five (5) employees must enroll.				

PART E – EMPLOYER PAID PARTICIPATION:

- 2-50 Eligible Employees:** A minimum of 60% of employees not covered by another dental plan are required to enroll. A minimum of two (2) must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of 5 employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.
- Medical Lock (Packaged Enrollment):** All members enrolled in any medical plan must enroll in Anthem dental. The medical plan billing for all medical carriers must be included with new group submission materials. Dental tiering must be identical on the medical and dental plans regardless of medical carrier. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

PART F – EMPLOYER PAID PLANS:

ANTHEM VALUE

Select Plan Design Active Passive **Deductible** \$50/\$150 Annual
Select Annual Maximum \$500 \$1,000

ANTHEM CLASSIC

Select Plan Design Active Passive **Select Annual Deductible** \$25/75 \$50/150
Select Annual Maximum \$1,000 \$1,500 **Annual Maximum Carryover** Yes No

Select Benefit Category for Endodontic, Periodontal & Oral Surgery Basic Major

Select Orthodontic Coverage (A minimum of 10 employees must enroll.)

- 50% coverage for adults and dependent children; Lifetime maximum to match annual maximum.
- 50% coverage for dependent children; Lifetime maximum to match annual maximum.
- No Coverage

ANTHEM ENHANCED

Select Plan Design Active Passive **Select Annual Deductible** \$25/75 \$50/150
Annual Maximum \$2,000 **Annual Maximum Carryover** Yes No

Select Orthodontic Coverage (A minimum of 10 employees must enroll.)

- 50% coverage for adults and dependent children; Lifetime maximum to match annual maximum.
- 50% coverage for dependent children; Lifetime maximum to match annual maximum.
- No Coverage

PART G – RATES SOLD:

Employee: \$	Employee + Spouse \$	Employee + Child(ren) \$	Family \$
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PRODUCER OF RECORD (if any) Completion of all fields required:

Name _____	Agency _____
Address _____	Phone () _____
City _____	State _____ Zip Code _____
E-mail Address _____	_____
_____	Tax ID Number _____
Producer Signature / Insurance Producer License ID #	

PREMIUM REMITTANCE AND SUBMISSION:

Anthem dental will bill for the first month's premium. Thereafter, the monthly premium payment along with the corresponding statement or invoice must be received by the first of each month. Contact Anthem Connect at 866-956-8602 or your Anthem Sales Representative with questions.

1. Select Payment Option:
 ACH - Include ACH Authorization Form and voided check
 CHECK WIRE
2. Complete application. Retain a copy for your files.
3. Each eligible employee must complete and sign a Membership Enrollment Form.
4. Send the Master Dental Contract Application, completed Membership Enrollment Forms and corresponding Dental Proposal(s) to:

Anthem Blue Cross and Blue Shield
13550 Triton Park Blvd
Mail Point KY0302 - A620
Louisville, KY 40223

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Anthem dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two.

Anthem dental will send a contract upon acceptance of the application. The contract will indicate the effective date of coverage. The contract is effective only after Anthem dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Anthem dental.

SIGNATURE BOX:

Signature of Authorized Company Official	Title	Date
Group Administrator/Future Correspondence Contact (please print)		Title
()	()	
Phone Number	Fax Number	E-mail Address

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