Employer Elect ***Plans***
Elect Dental

5429 Avenida de los Robles, Ste A
Visalia, CA 93291
Phone 559-733-1240 Fax 559-733-1314

Company Name: ____

Street Address/City/State/Zip: ______________________________________

Billing Address: ____

Phone No.:__________________ Fax No.: ________________ Employer Tax ID #: _________________

Company Contact Person: ______________________________ Email: ____________________________

Principle/Owner: _____________________________________ Title: ____________________________

Funding Method: **(Please select one)**

☐ **Standard(105)** ***Submit a void check with beginning check number _______***

☐ **Deposit (205)** ***Submit a deposit check made payable to Employer Elect***
Dental only, submit $1000
Dental and Vision, submit $1500

Elect Dental Coverage Selection

Deductible: 0 25 50 Other:______ Deductible Credit Y or N
*If yes, submit claims history

Preventive (%): 100 90 80 70 60 50% Apply Deductible Y or N

Basic (%): 100 90 80 70 60 50% Apply Deductible: Y or N

Basic service waiting period: 0 6 12 Months

Do you wish to waive the basic service waiting period for employees currently enrolled in your dental plan?
Yes No

Major (%): 100 90 80 70 60 50% Apply Deductible: Y or N

Major service waiting period: 0 6 12 Months

Do you wish to waive the major service waiting period for employees currently enrolled in your dental plan?
Yes No

Annual Maximum: 1000 1500 2000 Other: __________________
(Per Insured)

Orthodontia(%): 100 90 80 70 60 50% Apply Deductible: Y or N

Waiting Period: 0 6 12 24 Months

Included in Annual Maximum: Y or N

Lifetime Maximum: 500 1000 1500 2000

Coverage to age: 19 23 Other: _______

What percentile of Reasonable & Customary does the group wish to pay at: 70 75 80 85 90 95 100

Vision Rate **Elect Vision Coverage Selection: Yes or No**

Deductible: 10 20 25 Other:________

Eye Examine (%): 100 90 80 70 60 50% Apply Deductible Y or N

Once in every 12 months of coverage.

Frames (%): 100 90 80 70 60 50% Apply Deductible Y or N

Once in every 12 or 24 months of coverage.

Lens / Incl. Contacts (%):100 90 80 70 60 50% Apply Deductible Y or N

Once in every 12 or 24 months of coverage.

Annual Maximum: 100 200 Other:__________________

Claims will be processed at the Reasonable & Customary rate.

Dental Eligibility Guidelines

Terms:	Groups that employ full-time employees working at least 30 hours per week are eligible for this plan.
Employer Contribution:	Minimum 50% of the employee only rate
Employee Participation:	Minimum of 75% of all full-time employees
Dependent Participation:	None

Employer Information

A. Total No. of employees: _________________
B. Are part-time employees (20 to 29) hours weekly to be covered? ……………………..Yes or No
C. No. of eligible full-time employees (min. 30 hrs. weekly): _________________
D. Do you wish to offer coverage for domestic partners? …………………………………Yes or No
E. Probation period/waiting period for new employees: ________________ months

Requested Effective Date: _________/___________/__________.

Would you like to elect a Network? Yes or No If yes, which one:____________________
*Network option is $1.50 pepm

We have selected the Schedule of Benefits noted on the Coverage Selection options, which will be incorporated into our Master Plan Documents. We also agree to provide the required funding for these benefits immediately as requested by Ben-e-lect and as required by California state law.

Print name: ____

on the ___________________ day of ____________________ 20 _______

Signature of Company Officer: ***X***____

Title: ____

AGENT COMMISSION:

For **Deposit** and **Standard** funding, please indicate the dollar amount to be charged pepm in addition to the Ben-e-lect administration fee: $_______________.

Commissions payable to:____

AGENT'S CERTIFICATION

I herby certify that I have advised the client not to terminate any existing coverage until receiving written notification from Ben-e-lect that the coverage being applied for by this application is accepted.

Name of writing agent: ____

Agent Address/City/State/Zip: ____

Phone No.: ________________ Fax No.: ________________ S.S. # or Tax ID #: _________________

Writing Agent's Signature: X____

Name of Second writing agent:____

Agent Address/City/State/Zip: ____

Phone No.: ________________ Fax No.: ________________ S.S. # or Tax ID #: _________________

Second Agent's Signature: X____

CA License #0708953

PLEASE ATTACH A COPY OF YOUR PRIOR CARRIER'S DENTAL BENEFIT BOOKLET AND CURRENT CARRIER BILL