Dental Select Enrollment Kit

General Info

Producer:		Email:	
Phone:		Fax:	
Group Name:		Effective:	

Submission Checklist

	document/item	doc #	revised
☐	**Group Application**	APP.01.9000286	2017-06
☐	**Original proposal** – circle plan/rates sold		
☐	**First month premium payment** – check payable to Dental Select or Credit Card via Binder EFT Form	BBC.01.9000310	2015-11
☐	**EFT Authorization Form** – optional; complete bottom of EFT Form to pay premium via monthly bank draft	BBC.01.9000310	2015-11
☐	**Proof of Prior Coverage** – only required if sold plan has benefit waiting periods ☐ Summary of benefits from current carrier ☐ Last month's invoice from current carrier listing employees enrolled and effective dates		
☐	**Proof of Payroll Documentation** – only required if company owned/operated solely by family members ☐ Proof of establishment in state – e.g.: Articles of Incorporation, business license, etc ☐ Proof that enrollees are gainfully employed – e.g.: TWC statement, pay stubs, payroll statements, etc		
☐	**Current Group Census** – only required for groups with 2-5 lives		
☐	**Web Portal Signup Sheet** – for employer or broker access	UT2014 PSS	2013-03
☐	**Employee Enrollment Applications** *Required for all eligible including waivers and declinations.*	ENR.01.9000216	2015-07

Contact

Submit Paperwork to

Kilpatrick Companies, LLC
1050 Wilcrest Dr.
Houston, TX 77042

Call

800-833-8478

Internet

www.kilpatrickcos.com

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Kilpatrick COMPANIES

DentalSelect

Group Plan Application

GROUP INFORMATION

Group Name			Mailing Address		
SIC Code or Industry	Requested Effective Date		City	State	Zip Code
Physical Address			HR Contact & Title		
City	State	Zip Code	Phone #	Email	
Phone #	Fax #		Billing Contact & Title		
Nature of Business			Phone #	Email	

DESIGN YOUR PLAN

Select Preferred Enrollment

☐ Dental Only ☐ Dental & Vision ☐ Vision Only **ID Card Delivery** ☐ To Group ☐ To Employee

☐ Electronic Enrollment (834 File Format) For groups 50+ enrolled ☐ Spreadsheet (Dental Select authorized form only) ☐ Paper Forms

Dental Plan Options - Utah & Texas Only

Funding: ☐ Contributory Plan ☐ Voluntary Plan Type: ☐ Classic

Dental Plan: ☐ Discount - Silver Network* ☐ Co-Insurance PPO/MAC** ☐ Co-Pay ☐ Co-Insurance Passive PPO **Network:**** ☐ Gold ☐ Platinum

AD&D Plan Option: ☐ Contributory - Amount $ ____________ ☐ Voluntary

Beneficiary Designation Required - Additional form available with Employee Enrollment) Principal Sums range from $10,000 to $250,000. Refer to plan flyer for specifications

☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

Dental Plan Options - All Other States

Funding: ☐ Contributory Plan ☐ Voluntary Plan Network: Platinum

Dental Plan: ☐ Co-Insurance PPO/MAC ☐ Co-Insurance Passive PPO ☐ Discount

Select a Vision Plan - Applicable States

Funding: ☐ Contributory Plan ☐ Voluntary Plan

Plan: ☐ Vis 6 ☐ Vis 7 ☐ Vis 8 ☐ Vis 12 ☐ Other ______________________________

SOLD RATES – BASED ON PLAN DESIGN, COMPLETE RATES BELOW

	#1 ____________ Sold Rates	#2 ____________ Sold Rates	#3 ____________ Sold Rates	Vision Sold Rates	AD&D Sold Rates
Single:	____________	____________	____________	____________	____________
Employee/Spouse or E1D:	____________	____________	____________	____________	____________
Employee/Child(ren):	____________	____________	____________	____________	____________
Family:	____________	____________	____________	____________	____________

Monthly Administration Fee: $___________________________
($2.00 per employee: maximum $20.00)

First month's premium must be included with application

DentalSelect

Group Plan Application

DESIGN YOUR PLAN - (CONTINUED)

General Participation

	Dental	Vision		Dental	Vision		Dental	Vision
Number of Full Time Employees: (at least 30 hr. per week)	______	______	**Number of Employees Enrolling:**	______	______	**Number Waiving Due to Other Coverage:**	______	______
Employer Contribution Percentage for Employees:	______%	______%	**Employer Contribution Percentage for Dependent**	______%	______%	**Number of Employees Enrolling**	______%	______%

New Hire Waiting Periods

Employees will be eligible to enroll the first of the month following the required days of continuous full time employment with the group. Present employees who are eligible must enroll on the policy effective date, or within 31 days of group effective date. New employees must enroll within 31 days of the date they become eligible. **(Please complete Employee Category below)**

Employee Category

How long must a new hire be employed before being offered benefits? Benefits are available the first day of the month following:

- ☐ Exact Date
- ☐ 90 Days
- ☐ Date of Hire
- ☐ Waive at initial enrollment only*
- ☐ 30 Days
- ☐ Other: ________________
- ☐ 60 Days

*For initial group enrollment, all existing employees will be enrolled on effective date

Is the new hire waiting period different for any class of Employees (i.e. hourly/salary/management/non-management)? If yes, please identify below. **Minimum of 2 per class.**

Class:	**New Hire Waiting Period Days:**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Comparable Dental Plans

Does the Group now have a comparable dental plan which has been in force for the past 12 consecutive months?

☐ **Yes** ☐ **No**

If Yes:
Name of carrier: ______________________________

Waiting Period Waiver

☐ Waiting Periods ☐ Orthodontic

Waiting Periods Waived for Prior Comparable Coverage:

With proof of coverage and Member's effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior comparable coverage must accompany the application in order to reduce waiting periods.

The waiting periods for Basic, Major and Orthodontic services may be waived (in part or in their entirety) only for those Employees and Dependents covered on the Group's prior comparable plan. **To qualify for a waiver, the following documentation must accompany this application:**

- Prior carrier's Summary of Benefits
- Most recent Billing Statement, listing the covered employees eligibility date

Take-over Provisions

☐ Maximums & Deductibles

When take-over applies, both the maximum and deductible will be reviewed for take-over together. **To qualify for a take-over, the following documentation must accompany this application**:

- The total and any amount applied, per member for both maximum and deductibles

Terms & Conditions

By signing on the next page, company officer or authorized person:

- understands that the In-Network plan providers are not agents, representatives, nor employees of Dental Select.
- represents that all information on this application and any attachment is correct and complete to the best of his/her knowledge and belief.
- understands that no insurance will become effective until approved by the Insurance Company.
- understands that no agent has the authority to modify or waive any conditions of this application or the policy nor to bind the insurance company by making any promise of representation.
- agrees to maintain and furnish any records necessary to administer the policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation requirements must be met before the policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.
- understands that the employer is the plan sponsor and plan administrator and that neither Dental Select or ACE Property and Casualty Insurance Company, nor any insurance agent is a plan administrator nor fiduciary, as those terms are defined under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to participating employer's plan of groups insurance, and the questions regarding the tax or legal effects of the plan are to be resolved by the employer with advice of their own counsel.

(Continued on next page)

Terms & Conditions (continued)

(Continued from previous page)

The applicant hereby requests insurance for eligible persons based on the above statements and representations, and where applicable, agrees to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the Applicant.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Fraud Warning for Kentucky Applicants:
WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Signature - Company Officer or Authorized Person	Printed Name	Date

AH-38026

How To Submit Your Information

The first month's premium must accompany the application. Thereafter, Dental Select must receive the premium by the first day of each month to the P.O. Box address listed in the administrative guide.

1. Complete group plan application. Retain a copy for your files.
2. Have each employee complete and sign an employee enrollment form.
3. Submit electronic enrollment (834 file format) for groups 50+ employees enrolled (ongoing).
4. Send the original group plan application, completed employee enrollment forms and the first month of premium **payable to Dental Select** to:

Dental Select
5373 South Green Street, 4th Floor
Salt Lake City, UT 84123
Toll Free Fax: 888-998-8704

Any questions? Call 800-999-9789.

Please Select Payment Option:

☐ **Monthly Billing Invoice** – Initial premium MUST be submitted as a Binder Check.

☐ **EFT Electronic Funds Transfer** – By enrolling in EFT you understand that future premium payment will be deducted from designated account monthly. Completed EFT form MUST be included with this application.

Agent / Broker Information

Field	Value	Field	Value
Agent Name		Email	
Agency Name		Agent Phone #	
GA (if applicable)	Kilpatrick Companies	Agent ID #	
Agent's Account Manager Name		Account Manager Email	
Agent Signature (required)		Date	
Agent Address		City / State / Zip Code	

CHUBB®

Dental Select is a licensed third-party administrator and a licensed insurance agency (Utah license #5714). All Plans of insurance are underwritten by ACE Insurance Company, a member insurer of Chubb.

Group Binder EFT Authorization Form

Phone: 800-999-9789 **Fax:** 801-290-5099 **www.dentalselect.com**

Group Name:	Group #:	Payment Amount: $

Initial Binder Payment:

Binder Credit Card Authorization Authorizing Dental Select to withdraw only the one-time initial group binder payment.	Visa ☐ MasterCard ☐	Binder Amount to be Charged to Credit Card: $
Credit Card Number:	Expiration Date: __ __ / __ __	CID (3-digit security code)
Card Holder Name: (Last/First/Middle)		
Street Address:		
City:	State:	Zip Code:

I certify that the information above is true and correct and that as an authorized signer for the above named company, authorization is given to Dental Select to electronically process this one-time payment from the designated account.

Authorized Signature: Date Signed (MM/DD/YYYY):

Future Invoice Payment Options:

☐ **Option 1 – I wish to be invoiced for future payments** (no further action is needed).

☐ **Option 2 – I wish to enroll in recurring bank withdrawal for ongoing payments** (please complete following section).

Recurring EFT invoice payments may be set up or canceled in Dental Select's web portal at www.dentalselect.com.

Bank Withdrawal Authorization

Authorization to honor payments drawn by Dental Select, Salt Lake City, UT.

Exact Account Name (Please Print):		
Bank Name:	Bank Address:	
Account Number:	Routing #/ ABA #/ or Other Bank Code(s):	
Company Contact Person(s):		
Company Contact Phone #:	Company Contact Fax #:	Company Contact Email:

I certify that the information above is true and correct and that as an authorized signer for the above named company, authorization is given to Dental Select to electronically process payment from the designated account.

Authorized Signature: Date Signed (MM/DD/YYYY):

Name (Printed):	Title:

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DentalSelect

Portal User Account Request

Phone: 801-495-3000 **Toll Free:** 800-999-9789 **DentalSelect.com**

User Type

☐ Group ☐ Member ☐ Agent/Broker (If the user type is Agent/Broker, you MUST attach the group's authorization emai.)

Group Information

Group Name:

Group Number:

SE for Group:

Group Type: ☐ Fully – Insured ☐ Self – Funded*

Group HR Representative Information

User First Name:

User Last Name:

Is this proposed user a Dental Select member? ☐ Yes ☐ No

User Date of Birth:

User Email Address:

* Special Notes or Exceptions:

DentalSelect

Employee Enrollment Form

Phone: 800-999-9789 **Fax:** 888-998-8704 **www.dentalselect.com**

Must be completed in FULL – PLEASE PRINT – Enrollment is not valid without signature at the bottom of this page.

☐ No Benefit ☐ Dental ☐ Vision ☐ AD&D	First Name	Last Name

Mailing Address		
City	State	Zip Code
Phone Text: ☐ Yes ☐ No	Date of Birth (MM/DD/YYYY)	
Email Address		
SSN/Member ID#	Marital Status ☐ Married ☐ Single	Gender ☐ Male ☐ Female
Effective Date (MM/DD/YY)	Date of Hire (Required) (MM/DD/YY)	
Group Number	Subgroup/Dept. #	
Employer's Full Name		
Employer's Address		

Coverage Selection - Confirm available options with your employer. Check all that apply.

Dental Plan

☐ Discount - Silver
☐ Co-Pay - Gold
☐ Co-Pay - Platinum
☐ Co-Insurance PPO* - Gold
☐ Co-Insurance PPO/MAC - Platinum

* Where permitted by law

☐ Co-Insurance Passive PPO/Indemnity - Platinum
☐ ACA EHB Child Only
☐ Other ___________________

Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.
☐ High ☐ Low

Vision Plan

☐ Vis 1 ☐ Vis 2 ☐ Vis 3 ☐ Vis 4 ☐ Vis 5 ☐ Vis 6
☐ Vis 7 ☐ Vis 8 ☐ Vis 9 ☐ Vis 10 ☐ Vis 11
☐ Other _____________

AD&D Plan Option - Utah & Texas Only

Contributory - Amount $_______________
☐ Employee (Complete beneficiary info on Designation Form)
☐ Employee & Family (Complete individuals covered and sign page 2)

Voluntary
☐ AD&D - Amount $_______________ (Complete beneficiary info on Designation Form)
Principal Sums range from $10,000 to $250,000. Refer to plan flyer for specifications.

Individuals Covered - List individuals for whom you are enrolling and select plan option.

Coverage	Name	Gender	SSN	Date of Birth
☐ Dental ☐ Vision ☐ AD&D	Spouse Name - (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	Dependent Name - (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	Dependent Name - (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	Dependent Name - (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)
☐ Dental ☐ Vision ☐ AD&D	Dependent Name - (Last, First, MI)	Gender ☐ Male ☐ Female	SSN	Date of Birth - (MM/DD/YYYY)

For additional dependents include the Dependent Enrollment Form

Covered by other DENTAL Insurance? ☐ Yes ☐ No	If Yes, Name of other Dental Insurance Company	Name of Person Insured	Social Security Number

Authorization of Coverage

Authorization ☐ Check here to waive if no coverage is desired ☐ Check here to waive if you have additional coverage through another policy

I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claims and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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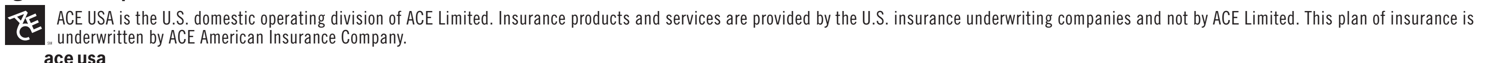
I agree and understand that if my employer is contributing towards the cost of any of the insurance products I have chosen to decline, I will not be entitled to any compensation for my non-participation.

Signature (Required) ______________________________ Date ______________



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