

General Info

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

Submission Checklist

document/item	doc #	revised
<input type="checkbox"/> Group Application	APP.01.9000286	2015-07
<input type="checkbox"/> Original proposal – circle plan/rates sold		
<input type="checkbox"/> First month’s premium check payable to Dental Select		
<input type="checkbox"/> Proof of Prior Coverage – <u>only required</u> if sold plan has benefit waiting periods		
<input type="checkbox"/> Summary of benefits from current carrier		
<input type="checkbox"/> Last month’s invoice from current carrier listing employees enrolled and effective dates		
<input type="checkbox"/> Proof of Payroll Documentation – <u>only required</u> if company owned/operated solely by family members		
<input type="checkbox"/> Proof of establishment in state – e.g.: Articles of Incorporation, business license, etc		
<input type="checkbox"/> Proof that enrollees are gainfully employed – e.g.: TWC statement, pay stubs, payroll statements, etc		
<input type="checkbox"/> Current Group Census – <u>only required</u> for groups with 2-5 lives		
<input type="checkbox"/> Web Portal Signup Sheet – for employer or broker access	UT2011 APP	2011-08
<input type="checkbox"/> Employee Enrollment Applications <i>Required for all eligible including waivers and declinations.</i>	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

Group Information

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

Design Your Plan

Select Preferred Enrollment

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

Dental Only Dental & Vision Vision Only

Dental Plan Options - Utah & Texas Only

Funding: Contributory Plan Voluntary Plan Type: Classic Choice Monarch (Utah Only)

Dental Plan: Discount - Silver Network* Co-Insurance PPO** EHB Child Only Network:** Gold Platinum
 Co-Pay Co-Insurance Indemnity Certified Plans† Platinum 2

AD&D Plan Option: Employee Employee & Family 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.

Dental Plan Options - All Other States

Funding: Contributory Plan Voluntary Plan Type: Choice
 Dental Plan: Co-Insurance PPO/MAC Co-Insurance Passive PPO Network: Network availability listed by state in the Participation Guidelines.

Select a Vision Plan - All States

Funding: Contributory Plan Voluntary Plan
 Plan: Vis 6z Vis 7z Vis 8z 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:	_____	_____	_____	_____	_____
Child Only 1:	_____	_____	_____	_____	_____
Child Only 2:	_____	_____	_____	_____	_____
Child Only 3+:	_____	_____	_____	_____	_____
Monthly Administration Fee: \$ _____ (\$2.00 per employee; maximum \$20.00)	First month's premium must be included with application.				

*Discount plan is not underwritten by ACE Property and Casualty Insurance Company

** Where permitted by law

† Additional certified plan selection form required.

Design Your Plan - (Continued)

General Participation

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

<p>How long must a new hire be employed before being offered benefits? Benefits are available the first day of the month following:</p> <p><input type="checkbox"/> Date of Hire</p> <p><input type="checkbox"/> 30 Days</p> <p><input type="checkbox"/> 60 Days</p> <p><input type="checkbox"/> 90 Days</p> <p><input type="checkbox"/> Exact date of hire</p> <p><input type="checkbox"/> Waive at initial enrollment only</p> <p><input type="checkbox"/> Other: _____</p>	<p>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.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Class:</td> <td style="width: 50%;">New Hire Waiting Period Days:</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	Class:	New Hire Waiting Period Days:	_____	_____	_____	_____	_____	_____
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: _____ Length of coverage: _____

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

Please Select Payment Option:

- EFT Electronic Funds Transfer** – Groups must enroll for recurring EFT on Web Portal.
Initial premium **MUST** be submitted as a Binder Check.
- Monthly Billing Invoice**

Any questions? Call 800-999-9789.

Agent / Broker Information

Agent Name	Email		
Agency Name	Agent Phone #		
GA (if applicable)	Agent ID #		
Agent Signature	Date		
Agent Address	City	State	Zip Code

NOTE: Please make a copy of this form for your records before submitting.

Dental Select Office Use Only

Approved by	Date Approved	Title	
Effective Date	Group #	Subgroup #	

5373 South Green St. 4th Floor
Salt Lake City, UT 84123
801-495-3000 800-999-9789
Fax 888-998-8709



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ace usa

User Type

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

Administrator Information

Group Name:
Group Number:
SE for Group:
Group Type: <input type="checkbox"/> Fully – Insured <input type="checkbox"/> Self – Funded*

User Information

User First Name:	
User Last Name:	
Is this proposed user a Dental Select member? <input type="checkbox"/> Yes <input type="checkbox"/> No	
User's Date of Birth:	User Email Address:

* Special Notes or Exceptions:

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

<input type="checkbox"/> No Benefit <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	First Name	Last Name
Mailing Address		
City	State	Zip Code
Phone	Text: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth (MM/DD/YYYY)
Email Address		
SSN/Member ID#	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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

<input type="checkbox"/> Discount - Silver	<input type="checkbox"/> Co-Insurance Passive PPO/Indemnity - Platinum
<input type="checkbox"/> Co-Pay - Gold	<input type="checkbox"/> ACA EHB Child Only
<input type="checkbox"/> Co-Pay - Platinum	<input type="checkbox"/> Other _____
<input type="checkbox"/> Co-Insurance PPO* - Gold	
<input type="checkbox"/> Co-Insurance PPO/MAC - Platinum	Dual Options - If applicable, select High or Low to indicate plan type, otherwise leave blank.
* Where permitted by law	<input type="checkbox"/> High <input type="checkbox"/> Low

Vision Plan

<input type="checkbox"/> Vis 1	<input type="checkbox"/> Vis 2	<input type="checkbox"/> Vis 3	<input type="checkbox"/> Vis 4	<input type="checkbox"/> Vis 5	<input type="checkbox"/> Vis 6
<input type="checkbox"/> Vis 7	<input type="checkbox"/> Vis 8	<input type="checkbox"/> Vis 9	<input type="checkbox"/> Vis 10	<input type="checkbox"/> Vis 11	
<input type="checkbox"/> 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.

<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	Spouse Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)
<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> AD&D	Dependent Name - (Last, First, MI)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN	Date of Birth - (MM/DD/YYYY)

For additional dependents include the Dependent Enrollment Form

Covered by other DENTAL Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of other Dental Insurance Company	Name of Person Insured	Social Security Number
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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** _____

 ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.