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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? _____ (FIRST OF THE MONTH FOLLOWING)
 _____ 30 DAYS _____ 60 DAYS _____ 90 DAYS

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:

	3 TIER RATES	# ENROLLED	TOTALS	4 TIER RATES	# ENROLLED	TOTALS
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 (APPLIES ONLY TO GROUPS ENROLLING LESS THAN 25 ON CDN DHMO) \$ 10.00

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 _____