California DENTAL
A DentaQuest Company

23291 Mill Creek Drive #100 Laguna Hills CA 92653 ♦ Phone (949) 830-1600 Toll-Free (877) 4-DENTAL (433-6825) ♦ Fax (949) 830-1655
www.caldental.net e-mail rfps@caldental.net

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) ___30DAYS ___60 DAYS ___90DAYS

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:

A75 _____
A100 _____
A150 _____
A200 _____
A250 _____ OTHER _____

3 TIER RATES	# ENROLLED	TOTALS
EO $ _____	x _____	= $ _____
+1 $ _____	x _____	= $ _____
+2 $ _____	x _____	= $ _____

4 TIER RATES	# ENROLLED	TOTALS
EMPLOYEE ONLY $_____	x _____	= $_____
E + SPOUSE $_____	x _____	=$_____
E + CHILD(REN) $_____	x _____	= $_____
E + FAM $_____	x _____	= $_____

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 _____