PREMIER ACCESS | ACCESS DENTAL

EMPLOYER APPLICATION

EMPLOYER INFORMATION

Group No. (to be assigned by Premier)**:** _____ **Effective Date:** _____

Employer Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ Federal Employer ID: _____

Benefits Administrator Name: _____

Phone: (____) _____ Fax: (____) _____ E-mail Address: _____

Billing Contact Name *(if different from above)*: _____

Phone: (____) _____ Fax: (____) _____ E-mail Address: _____

Billing Street Address *(if different from above)*: _____

City: _____ State: _____ Zip: _____

Associated Company(ies) *(subsidiaries, branches, other divisions)* and Address(es). If necessary, attach list:

_____

Standard Industry Classification (SIC) Code: _____

Industry Description: _____

Type of Organization: ❑ Corporation ❑ Non-Profit ❑ Partnership ❑ Sole Proprietorship
❑ Municipality ❑ Union ❑ Trust Fund ❑ Other _____

Total number of employees: _____ Number of employees not eligible: _____
(Part-time,in waiting period, terminations, etc.)

Number of employees eligible: _____ Number of employees participating: _____

ELIGIBILITY

CATEGORIES OF ELIGIBILITY *(Subject to Premier's approval)*:

☑ **Actively-at-Work Employees** (employees scheduled to work at least _____ hours per week.) A bona-fide employee/employer relationship is required to be maintained, i.e. the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs *(e.g., FICA, FUI, SUI and Worker's Compensation)* normally associated with a bona-fide employee relationship. Generally, employees must be actively at work before coverage commences. Any other eligibility arrangements require prior approval from Premier.

- ♦ Employees are eligible to continue group coverage for _____ month(s) while on an Employer approved temporary personal leave of absence *(maximum of 6 months)*.
- ♦ Employees are eligible to continue group coverage for _____ month(s) while on an Employer approved medical leave of absence *(maximum of 6 months)*.

❑ Dependents *(Dependent child eligibility requirements are defined by the Employer Group Policy. Supporting documentation of dependent eligible status must be submitted with this form for dependent children age 19 or over for the enrollment to be processed and claims paid.)*

❑ Other types of Subscribers *(attach description)*

❑ Dependent *(attach description of any Employer dependent prerequisites different from standard Premier requirements.)*

* *All references to "Premier" herein refer to Premier Access Insurance Company*

CATEGORIES NOT ELIGIBLE (EXCLUDED)

☑ Part-time Employees (employees scheduled to work less than _____ hours per week.)

❑ Other *(please specify)* _____

ELIGIBILITY WAIT PERIOD/EFFECTIVE DATE FOR EMPLOYEES
Eligibility Wait Period must be satisfied before an Employee becomes Eligible for coverage.

Existing Employees must be employed Full-time with the Employer for _____ ❑ days ❑ months ❑ hours.

New Employees must be employed Full-time with the Employer for _____ ❑ days ❑ months ❑ hours.

After the Eligibility Wait Period is satisfied, coverage will be effective on:

❑ 1st of the month following the date of attainment of eligibility ❑ The date of attainment of eligibility

Eligibility Wait Period waived for previously Covered Employees rehired within three months or resuming Actively at Work status within three months: ❑ Yes ❑ No

BENEFIT PLAN AND PREMIUM

Please attach a copy of the original proposal document issued by Premier that lists the plan provisions and rates for the plan you are choosing.

FIRST MONTH'S PREMIUM Check attached in the amount of $ _____

BENEFIT PLAN OPTION (e.g., Plus Plan 6, PPO 6/124) _____

COVERAGE RIDERS ❑ None ❑ Orthodontia ❑ TMJ ❑ Other: _____

EMPLOYER CONTRIBUTION

Employee Only $ _____ or _____ % of Premier prepayment premiums/fees.

Dependents $ _____ or _____ % of Premier prepayment premiums/fees.

MINIMUM PARTICIPATION REQUIREMENTS
A minimum of _____ % of total Actively-at-Work Employees must enroll during the initial enrollment period and must be maintained thereafter by the group.

NATIONAL PPO NETWORK (Available as an Option)
The Applicant will use the national PPO network for out-of-state employees.

❑ Yes ❑ No ❑ N/A (no out-of-state employees)

PRIOR COVERAGE

The Applicant has prior dental coverage for Employees: ❑ No ❑ Yes

If Yes, please complete the following: Carrier Name: _____

Policy Number: _____

Carrier Phone Number: _____

COBRA

The Applicant is subject to (check one): ❑ Federal COBRA (more than 20 employees) ❑ Cal-COBRA (up to 20 employees)

Does the Applicant currently have COBRA or Cal-COBRA enrollees? ❑ Yes ❑ No
(*If yes, please attach a list including name(s) and original effective date(s) of COBRA coverage and a copy of COBRA election statement.)*

Please specify the manner in which COBRA Premiums will be billed for your company if you are subject to Federal COBRA. (Note that Cal-COBRA is always billed to the COBRA member.)

- ❑ COBRA members will submit premiums directly to the employer group. Premier will bill the group for all COBRA premiums.
- ❑ COBRA members will submit premiums directly to a Third Party Administrator (TPA). Premier will bill the TPA for all COBRA premiums. Please specify the name and address of TPA below.

  Name: _____

  Address: _____

EMPLOYER STATEMENT OF UNDERSTANDING

This application shall be the basis for the issuance of coverage under the Policy and Certificate and shall become a part thereof. Premier reserves the right to terminate group coverage or the coverage of any individual Covered Person if the contract holder or individual Covered Person has made any material misrepresentation.

PAYMENT OF PREMIUMS AND/OR FEES: Premiums and/or fees are due on the first day of each month for which coverage is provided. Delinquent payments shall be subject to late charges of one and one-half percent per month. If payment is not received from the Employer, coverage for all Covered Persons will be terminated on the last day of the month for which premium payment was received. Termination of coverage, including cancellation due to nonpayment of premium, may be applied retroactively. Any other payment arrangements require prior approval by Premier. Claims for covered services shall not be paid until the premium payment for the month of service has been received. If a Covered Person receives dental services after coverage is terminated or lapses, the Covered Person is responsible to reimburse Premier for any payments made by Premier for such services.

VERIFICATION OF ELIGIBILITY: Verification of eligibility does not guarantee payment of claims. Retroactive eligibility changes supercede verifications of eligibility.

CHANGES IN PARTICIPATION OR PREMIUM PERCENTAGES: Coverage and premiums are based, in part, on the number of Covered Persons, the percentage of Employees and Dependents participating and the percentage of premium paid by the Employer. If any of these fall below levels accepted by Premier or below the level upon which the premium has been based, Premier may terminate the coverage by giving notice to the Employer. Additionally, if misrepresented in the application, the employer is responsible for any resulting losses incurred by Premier.

MANDATORY BINDING ARBITRATION: As more fully set out in the Policy and Certificate, we agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the Policy. If a face-to-face hearing is involved in the arbitration, the hearing shall be conducted in Sacramento, CA. By enrolling in this plan, Employer and Covered Persons waive their constitutional right to a trial before a jury or judge. Any dispute alleging the malpractice, negligence and/or wrongful act of a provider, shall not include Premier and shall include only the provider subject to the allegation.

I certify that all the information contained in this application is correct to the best of my knowledge and all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees. I certify that I have read, understand and concur with the provisions of the Employer Statement of Understanding above.

Dated at _____ this _____ day of _____, 20_____

Print Name and Title _____

Authorized Employer Signature *(must be an officer)* _____

PREMIER ACCESS INSURANCE COMPANY, P.O. BOX 659010, SACRAMENTO, CA 95865-9010

Application Check List

- ❑ **Employer Application**: The application should be completed and signed by the client and the broker.
- ❑ **Employee Applications and Waivers**: An enrollment application or waiver form from all employees eligible for coverage must be included.
- ❑ **Proposal document**: A copy of the original proposal document issued by Premier that lists the plan provisions and rates for the benefit plan you are choosing
- ❑ **Deposit**: A check from the employer that will be applied to the first month's premium must be included.
- ❑ **Prior Carrier's Billing Statement**: A copy of the most recent billing statement from the prior carrier, if there is prior coverage, must be included.
- ❑ **COBRA Information**: A list of all former employees/dependents on COBRA which includes the qualifying reason and qualifying date of COBRA coverage plus a copy of the COBRA election statement(s) must be included.
- ❑ **State Wage and Tax Withholding Statement (DE-9C in CA)**: For groups with 50 or fewer eligible employees, a copy of the employer's most recent quarterly statement is required.

BROKER INFORMATION

BROKER STATEMENT:

I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the applicant is a bona-fide business establishment. I certify all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined. I understand that no agent has power on behalf of Premier to make or modify any request or application for insurance, or to bind Premier by making any promise or representation or by giving or receiving any information. I further understand that no insurance will be effective until Premier accepts the Employer group in writing. No contract of insurance is to be implied in any way on the basis of the completion and submission of this application.

Dated at _____ this _____ day of _____, 20_____

Broker ID: _____ Broker Name: _____

Agency ID: _____ Agency Name: _____

Federal Tax Identification Number: _____

SALES REPRESENTATIVE

Signature: _____ Date _____

APPROVAL

Sales Manager: _____ Date _____

Underwriting: _____ Date _____

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Dental PPO coverage is provided by Premier Access.
DHMO coverage is provided by Access Dental Plan in California.
1[The Premier Access Vision Plan is administered by MESVision® and is underwritten by the Gerber Life Insurance Company of White Plains, NY.]
*All references to "Premier Access" herein refer to Premier Access Insurance Company