AgBenefits
Dental Group Application

The following form should be filled out completely and accurately. Please type or print neatly using black ink.

GROUP INFORMATION

Group Name: *(Note: Enter the legal name of the group, including any punctuation and abbreviations.)*

Street Address: | City: | State: | Zip Code:

Mailing Address: | City: | State: | Zip Code:

Telephone Number: ( ) – | Fax Number: ( ) – | Website Address:

Type of entity: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Association
☐ Government ☐ Non-Profit ☐ Other

Description of Business: | Standard Industry Code (SIC): | Years in Business:

Tax Identification Number (TIN):

Location of corporate/parent headquarters: ☐ Same as above ☐ Other

Are other divisions, subsidiaries or affiliates covered under this plan? ☐ No ☐ Yes
If yes, please list below:

Name	*Location*	*Relationship*

Primary Contact Person: | Title:

Telephone Number: ( ) – | Fax Number: ( ) – | Email Address:

Description of eligible employees: ☐ All full-time employees ☐ Other _____

Are any employees excluded from eligibility? ☐ No ☐ Yes, If yes, describe: _____

Note: Employees must work a minimum of 30 hours per week in order to be eligible for coverage. The waiting period for all employees is 30 days, with coverage to be effective the first of the month following completion of the waiting period.

Total number of full-time employees: _____

Total number of part-time employees: _____

Total number of eligible employees: _____

Total number of employees enrolling in this plan: _____
(Minimum participation is 75% of eligible employees.)

Total number of COBRA eligible members enrolling: _____
(Prior carrier COBRA election forms must be submitted.)

Total number of employees waiving coverage: _____

Total number of employees in the waiting period: _____

Employer Contributions:

Line of Coverage			*Dental*
For employee coverage	☐ %	☐ $	_____
For dependent coverage	☐ %	☐ $	_____

Authorization

I, the undersigned, understand and agree to the following…

1) Acceptance of this group for coverage and the final rates are based upon the information contained herein and the census of actual enrollees. Any material misrepresentation, whether intentional or unintentional, will permit AgBenefits to terminate such coverage and to pursue all other legal remedies available.
2) Terms and conditions stated in this document as attested by the signature below, effective on the date of the signature.
3) AgBenefits Privacy Policy Statement. (visit www.youragbenefits.com to view)
4) Plan year renewals will be delivered to the group 45 days before renewal date, if decision is not received by the Contract Administrator by the 15th of the month prior to renewal, the plan will auto-renew with quoted renewal rates.
5) My representative has explained the coverages, limitations, exclusions and other details of the coverage for which I applied.

Name: _____ Title: _____ Company: _____

Signature: _____ Date: ___/___/___