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Group Dental Application

(For new and renewing Small Employers)

Company Name ______________________________

Street Address ______________________________

City, State, ZIP ______________________________

Company Ph# (__________) ______________________________

Nature of Business ______________________________

A. PLAN/BENEFIT OPTIONS

The SelectHealth Dental service area includes the entire state of Utah. For dental coverage, please select one of the SelectHealth Dental® options:

- ❑ **Traditional**

  Employees can choose between the Classic, Prime, or Fundamental networks.

- ❑ **Tiered Plan**

  Employees have access to both the Prime and Fundamental networks.

B. DURATION OF GROUP DENTAL INSURANCE CONTRACT

If SelectHealth's minimum employee participation and Employer contribution requirements are satisfied, the Group Dental Insurance Contract and its terms shall commence on the effective date for a term of 12 months.

- Effective Date: ______________________
- Contract Term: 12 months
- Termination Date: ______________________

C. MONTHLY PREMIUM

On or before the first day of each month, the Employer shall pay SelectHealth the premium per the rate schedule.

D. DENTAL PAYMENT SUMMARY

In addition to any other applicable premium, members shall pay the appropriate deductible and copay/coinsurance amount on the attached Dental Payment Summary. "Not Covered" on the Dental Payment Summary indicates that the service is not covered regardless of any other statement of coverage.

E. EMPLOYEE RECONCILIATION

________ Number of full-time employees*

________ Number of employees enrolling

________ Number of ineligible employees (part time, etc.)

________ Number of employees waiving due to other group dental coverage

________ Number of employees waiving without other group dental coverage

________ Number of employees currently in a new hire waiting period

*Owners, officers, partners, and all other employees who work no less than 30 hours per week on a regular basis wherein an Employer/employee relationship exists and where taxes are deducted from a salary. Independent contractors, leased, part-time, temporary, and retired employees are not eligible.

F. DENTAL PLAN COVERAGE

Employer acknowledges that the Contract is entered into by SelectHealth in reliance upon the Employer supplying complete and accurate information. This document shall be considered to be material representations of fact by Employer to SelectHealth. Employer represents to SelectHealth that the information provided in this Application is accurate.

G. ELIGIBILITY, CONTRIBUTION, AND ENROLLMENT CRITERIA

Mandatory employee eligibility and enrollment requirements that the Employer must satisfy as a condition to the initial and continued effectiveness of this contractual arrangement are as follows:

1. **Employer Monthly Contribution and Minimum Employee Enrollment Requirements***

   ❑ **Contributory** (Employer must contribute an amount equivalent to at least 50 percent of the single coverage monthly Premium. The Employer contribution must be consistent for all employee classes.)

   Requirements for Contributory

   - Employers with up to four eligible employees after valid waivers – 100 percent of eligible employees must participate
   - Employers with five or more eligible employees after valid waivers – 75 percent of eligible employees must participate

   ❑ **Voluntary** (Employer is not required to contribute to the employees' monthly premium.)

   Requirements for Voluntary

   - Employers with one to 50 enrolling employees - 30 percent must participate

   *Employees waiving coverage due to other group dental coverage will not be counted toward participation.

2. **Newly Eligible Employees**

   The Employer Waiting Period* is:

   ❑ 0 months (employee is eligible on the first of the month following hire date) ❑ 1 month ❑ 2 months

   ❑ Dual waiting periods for separate classes (classes determined by Employer) ________________ /________________

   The Effective Date will be the first day of the next calendar month following the Employer Waiting Period.

**The Employer Waiting Period can only be changed twice—once at renewal and once outside of the renewal period.*

3. **Minimum Number of Employees**
   A minimum of two employees must be approved for group eligibility at all times. For the determination of a group of two, the spouse of the Employer will not be considered as an eligible employee.

   Orthodontia Coverage: A minimum of 10 employees must be approved for group eligibility at all times.

4. **Dependent Age Limitations**
   Dependent children are eligible for coverage up to age 26, unless they meet the criteria for disabled children as specified in the Certificate of Coverage.

5. **Termination of Coverage**
   Employee and dependent(s) coverage will terminate as of the end of the month in which termination of eligibility occurs. However, when an event causing loss of eligibility should have resulted in a member's retroactive termination, but the retroactive termination is not allowed under federal or state law, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for rescissions (as defined in the Group Health Insurance Contract).

6. **Leave of Absence**
   Eligible employees are granted a leave of absence by the employer for up to 60 days.

7. **Employee Status**
   A person may only be considered an employee if the Employer withholds and pays to the government Social Security and Medicare taxes and income tax withholding on the employee's wages. However, leased employees may also be eligible.

H. SIGNATURE

Coverage, if approved, is made on the basis of information provided to SelectHealth by the Employer and its employees and is subject to the above criteria as well as properly completed employee applications. Employer understands that SelectHealth is relying on such information in making decisions about coverage and payment. Employee (Subscriber) applications must be submitted to and approved by the SelectHealth before the proposed effective date. Otherwise, SelectHealth may delay the effective date of issue of this Contract. During regular business hours, SelectHealth will have the right to audit Employer's payroll records before, during, or following the term of the contract to verify employee enrollment and eligibility data, which may be relevant to enforcement of the terms of the Group Dental Insurance Contract. Employer applies to SelectHealth for group dental coverage. This Group Dental Application and the Group Dental Insurance Contract (including the Dental Payment Summary) become the agreement between SelectHealth and Employer. In case of discrepancies, the Group Dental Insurance Contract will prevail over this document.

This Group Application, along with the Group Dental Insurance Contract, must be signed by the Employer and received by SelectHealth before the Contract can be finalized. The Employer understands and agrees that any coverage provided will be limited according to the terms of this Group Application and the Group Dental Insurance Contract (including the Dental Payment Summary).

Company Name ____ Date ________________

Authorized Representative Signature ____

Authorized Representative (print name here) ____

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