

## Large Group Data Summary Dental

Date Submitted \_\_\_\_\_ Date Needed \_\_\_\_\_ Effective Date Requesting \_\_\_\_\_  
 Current Contract Renewal Date \_\_\_\_\_ Sales Rep. \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_  
 Company Name \_\_\_\_\_ Broker \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### ATTACHMENT CHECKLIST

- Groups with less than 100 enrollees **must** provide the following:
- Current Plan Summary of Benefits**
  - Prior Month's Insurance Bill**
  - \*Current Census (enrolled + not enrolled specified)**
  - Contributory vs. Voluntary Plan**
  - Experience Reports (if available)
  - Rate History (past two years)

- Groups with more than 100 enrollees **must** provide the following:
- Current Plan Summary of Benefits**
  - Prior Month's Insurance Bill**
  - \*Current Census (enrolled + not enrolled specified)**
  - Contributory vs. Voluntary Plan**
  - Experience Reports (past two years)**

\*Census **must** include age or date of birth, gender, and tier

### SUMMARY OF EMPLOYEES

	In Area	Out-of- Area	Total		In Area	Out-of- Area	Total
Eligible Employees	_____	_____	_____	Have Signed Waivers of Coverage	_____	_____	_____
Currently Covered on Plan	_____	_____	_____	In New-Hire Waiting Period	_____	_____	_____

### ELIGIBILITY GUIDELINES

Minimum Hours Per Week \_\_\_\_\_ New Employees are covered on \_\_\_\_\_ of month following \_\_\_\_\_ days/months of employment  
 Employee's Coverage Terminates on  Date of Termination  End of Month  
 Are retirees covered?  Yes  No If yes, please attach retiree policy.  
 Does this group have a rehire policy?  Yes  No If yes, please attach rehire policy.  
 Does this group have a leave policy?  Yes  No If yes, please attach leave policy.  
 Waiting periods for dental benefits, if applicable \_\_\_\_\_

SelectHealth allows 60 days for non-F? >A leave and does not include any provisions for rehires.

### COMPANY INFORMATION

Current Funding Method:  Fully Insured  Self Funded\*\*  
 Requested Funding Method:  Fully Insured  Self Funded (Group must have 100 or more enrollees)  
 Current Carrier/Administrator  5+yr  4yr  3yr  2yr  1yr \_\_\_\_\_  
 Prior Carrier/Administrator  5+yr  4yr  3yr  2yr  1yr \_\_\_\_\_  
 Description of Industry or Service Provided (SIC Code) \_\_\_\_\_

**Current Dental Rates:**

Employee \$ \_\_\_\_\_ Employee + Spouse \$ \_\_\_\_\_ Employee + Child(ren) \$ \_\_\_\_\_ Employee + Child \$ \_\_\_\_\_ Family \$ \_\_\_\_\_

**Employer Contributions: (if applicable)**

Employee % \_\_\_\_\_ Employee + Spouse % \_\_\_\_\_ Employee + Child(ren) % \_\_\_\_\_ Employee + Child % \_\_\_\_\_ Family % \_\_\_\_\_

Benefits Adjusted \_\_\_\_\_

Proposed Renewal Increase % \_\_\_\_\_ Match Current Benefits? \_\_\_\_\_

\*\*Groups that are currently self funded must provide:

- Current Census  Funding Data Sheet Form
- 24 Most Recent Months of Experience  Current Plan Summary of Benefits

Comments \_\_\_\_\_