For PHP use Only

BPL#: _____

Effective Date: _____

Renewal Date: _____

Rate Basis: _____

Approved By: _____

Date Approved: _____

DENTAL
Employer Group Application

Application is being made to the following PHPcompany for dental coverage: (check one)

☐ Physicians Health Plan of Northern Indiana - for companies headquartered in the following Indiana counties: Adams, Allen, DeKalb, Huntington, Noble, Wells, and Whitley.

☐ PHP Insurance Company of Indiana, Inc. - for companies headquartered in Indiana counties other than those mentioned above.

Effective Date for Beginning Coverage: _____

Benefit Plan Number Requested: _____

Current Medical Insurance Carrier *(if applicable)*: _____

Current Dental Insurance Carrier *(if applicable)*: _____

GENERAL INFORMATION

1. Employer Legal Name: _____

2. DBA Name ***(if applicable)***: _____

3. Plan Administrator *(primary contact)*: _____

   Privacy Contact: _____
   Person authorized to receive protected health information in compliance with HIPAA Privacy

4. Telephone #: _____ Fax #: _____

5. E-Mail Address: _____

6. Type of Business: _____ Standard Industrial Classification (SIC Code): _____

7. Legal Status: ☐ Corporation ☐ Partnership ☐ LLC

   ☐ Proprietorship ☐ Other _____

   Tax ID #: _____ Date Business Established: _____

8. Physical Address: _____
   Street

   _____
   City State Zip County

9. Billing Contact Name: _____

Billing Address: _____
Street

_____
City State Zip County

10a. Please list any affiliates, subsidiaries, branches, or other companies that can legally be filed under one tax return.

_____
Name Street

_____
City State Zip County

10b. Any affiliates, subdivisions, branches, etc. to be covered under this plan? ☐ Yes ☐ No

If yes: _____
Name of Company # of Total Employees # of Employees to be Insured

ELIGIBILITY/BENEFITS

11. Based on your current payroll list, how many employees do you have in each category?

	Enrolling Company	Affiliates/ Subsidiaries
Full-time (30 hours or more per week):	_____	_____
Part-time (less than 30 hours per week):	_____	_____
Seasonal/Temporary:	_____	_____
Other ***(please identify)***:_____	_____	_____
Total Employees	_____	_____

Number of Employees Enrolling in Dental Plan: _____

Number of Employees Eligible for Dental Coverage: _____

Number of Employees Waiving Dental: _____

12. **Dental Employer Contribution** Toward Dental Premium: By Class (e.g., hourly, salary, union, if different)
Note: The employer must contribute a minimum of 50% of the 'employee only' cost of dental insurance or 50% of the combined 'employee only' PHP medical and dental insurance premium for each covered employee. If employer pays entire cost, no eligible person may waive coverage.

Class 1 _____	$ Amount or % of Employee Premium: _____	$ Amount or % of Dependent Premium: _____
Class 2 _____	$ Amount or % of Employee Premium: _____	$ Amount or % of Dependent Premium: _____

13. **Waiting Period** (By Class e.g., hourly, salary, union, if different from each other) (Period i.e., 30, 60, 90 days or 1, 2, 3 months):

Class 1 _____ Waiting Period: _____ *(circle one)* Months Days Years

Waiting period applies to: ☐ Future employees only ☐ Current employees in waiting period & future employees

Coverage begins: ☐ Day waiting period is specified ☐ First of the month following waiting period
☐ Day after waiting period is specified ☐ Day of employment

Class 2 _____ Waiting Period: _____ *(circle one)* Months Days Years

Waiting period applies to: ☐ Future employees only ☐ Current employees in waiting period & future employees

Coverage begins: ☐ Day waiting period is specified ☐ First of the month following waiting period
☐ Day after waiting period is specified ☐ Day of employment

14. When does coverage end for terminated employees? ☐ Date of termination ☐ End of the month after date of termination

15. Do you provide Workers' Compensation for all employees? ☐ Yes ☐ No
If no, please list employees not covered:

Name	Title	Reason Not Covered

Current Workers' Compensation Carrier: _____

16a. Are you required by law to offer COBRA coverage to your employees for the current calendar year? ☐ Yes ☐ No

16b. Are any present or former employees or dependents currently on or eligible for COBRA continuation? If yes, please provide the following: ☐ Yes ☐ No

Name	Qualifying Event	Date COBRA Started	Date COBRA Coverage Expires

17. Continuation of coverage while on an approved layoff or leave of absence (This layoff or leave of absence provision runs concurrent with COBRA when the employer must comply with COBRA).

☐ 60 Days ☐ Other*: _____

**Subject to Underwriting approval.*

The insurance applied for is not in force until approved by PHP.
The undersigned applicant certifies that all answers contained in this application are true and complete.

Applicant Signature	Print Applicant Name	Date
Licensed Broker Signature	Print Broker Name	Date

Physicians Health Plan
of Northern Indiana, Inc.

PHP Insurance Company
of Indiana, Inc.

8101 West Jefferson Boulevard ● Fort Wayne, Indiana 46804-4163 ● (260) 432-6690 ● 1-800-982-6257 ● FAX (260) 432-0493
www.phpni.com

DENT 003 08/08