



GROUP BILLING UNIT  
DO NOT WRITE IN SHADED AREA

# DENTAL MASTER GROUP APPLICATION

## For Groups with no Blue Shield Medical Coverage (for 2-299 employees)

DENTAL HMO	DENTAL PPO
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**PLEASE TYPE OR PRINT CLEARLY. USE BLACK INK.**

<b>1</b>	FULL LEGAL BUSINESS NAME	EFFECTIVE DATE		
<b>2</b>	BILLING ADDRESS (NUMBER, STREET, CITY, STATE, ZIP) IF P.O. BOX, COMPLETE NO. 3 BELOW	COUNTY		
<b>3</b>	PHYSICAL ADDRESS OF BUSINESS (IF DIFFERENT FROM ABOVE)			
<b>4</b>	GROUP CONTACT PERSON NAME/TITLE	GROUP CEO NAME	PHONE NUMBER ( )	FAX NUMBER ( )
<b>5</b>	LEGAL ENTITY <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> IF GROUP HAS A CURRENT MEDICAL PLAN WITH BSC IF SO, WHAT IS GROUP NUMBER?	EMPLOYER TAX ID NUMBER	
<b>6</b>	TYPE OF BUSINESS (PROVIDE AS MUCH DETAIL AS POSSIBLE), LIST THE MAJOR INDUSTRIES AND PRODUCTS/SERVICES OF YOUR BUSINESS. IF KNOWN, LIST THE STANDARD INDUSTRY CLASSIFICATION CODE(S) (SIC CODE) IN WHICH THE BUSINESS IS CLASSIFIED.			
<b>7</b>	LIST SUBSIDIARY, OR AFFILIATED COMPANIES. GIVE NAME(S), ADDRESS(ES). IDENTIFY WHICH SUBSIDIARIES SHOULD BE INCLUDED IN THE COVERAGE.			
IF NO SUBSIDIARY/AFFILIATED COMPANIES APPLY, CHECK "N/A" <input type="checkbox"/> N/A				
<b>8</b>	PRIOR DENTAL CARRIER(S)	DO YOU OFFER OTHER CARRIER'S DENTAL PLANS TO YOUR EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, ENTER DATES OF OPEN ENROLLMENT PERIOD FROM: _____ TO: _____	EMPLOYEES TO BE EFFECTIVE ON
IF OTHER DENTAL CARRIER IS OFFERED (IN ADDITION TO BLUE SHIELD) LIST CARRIER NAME AND # OF EMPLOYEES COVERED BY THIS CARRIER				
		NAME	# EMPLOYEES	
<b>9</b>	FUTURE EMPLOYEE WAITING PERIOD: _____ MONTHS (MINIMUM 0, MAXIMUM 6 MONTHS). DOES THIS WAITING PERIOD APPLY TO CURRENT EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
UNLESS OTHERWISE NOTED, EMPLOYEES HIRED ON THE 1ST OF THE MONTH WILL BE EFFECTIVE ON THE 1ST OF THE MONTH FOLLOWING THE COMPLETION OF THE WAITING PERIOD. EMPLOYEES EFFECTIVE DATE IS THE FIRST BILL DATE FOLLOWING THE WAITING PERIOD.				
<b>10</b>	TOTAL # OF ALL EMPLOYEES	TOTAL # OF ELIGIBLE EMPLOYEES	TOTAL # OF ALL ACTIVE ENROLLING EMPLOYEES	
NUMBER OF FULL TIME EMPLOYEES IN WAITING PERIOD: _____ NUMBER OF EMPLOYEES WHO ARE DECLINING COVERAGE _____				
<b>EMPLOYER IS RESPONSIBLE FOR COLLECTING REFUSAL OF COVERAGE.</b>				
FOR EMPLOYER CONTRIBUTION, ENTER PERCENT OF DUES PAID BY EMPLOYER FOR EEs (EMPLOYEES) AND DEPs (DEPENDENTS). <b>IF 100%, ALL ELIGIBLE EMPLOYEES MUST ENROLL.</b>				
	<b>DENTAL HMO</b>	[ FOR EEs _____ % [ FOR DEPs _____ %	<b>DENTAL PPO</b>	[ FOR EEs _____ % [ FOR DEPs _____ %

<b>11</b>	DO YOU WISH TO OFFER COVERAGE FOR YOUR PERMANENT EMPLOYEES WHO WORK FEWER THAN 30 BUT NOT FEWER THAN 20 HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO
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<b>12</b>	DO YOU WISH TO OFFER COVERAGE FOR DOMESTIC PARTNERS? <input type="checkbox"/> YES <input type="checkbox"/> NO FOR GROUPS OF 51+: IF YES, COVERAGE FOR: <input type="checkbox"/> SAME SEX <input type="checkbox"/> SAME SEX AND OPPOSITE SEX
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### DENTAL BENEFITS

<b>13</b>	<input type="checkbox"/> DENTAL PPO PLAN - SMILE BASIC VOLUNTARY <input type="checkbox"/> DENTAL PPO PLAN - SMILE DELUXE <input type="checkbox"/> DENTAL HMO BASIC <input type="checkbox"/> DENTAL HMO DELUXE <input type="checkbox"/> DENTAL PPO PLAN - SMILE BASIC <input type="checkbox"/> DENTAL PPO PLAN - SMILE DELUXE GOLD <input type="checkbox"/> DENTAL HMO VOLUNTARY <input type="checkbox"/> DENTAL PPO PLAN - SMILE <input type="checkbox"/> DENTAL PPO PLAN - SMILE PLUS <input type="checkbox"/> DENTAL HMO PLUS
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### PAYMENT

<b>14</b>	THE GROUP HEREWITH TENDERS THE AMOUNT OF \$ _____ AND, IN CONSIDERATION OF APPROVAL OF THE APPLICATION IT WILL MAKE AND IN EVENT OF SUCH APPROVAL, PROMISES TO PAY THIS COMPANY AS APPROPRIATE ANY BALANCE NECESSARY TO CONSTITUTE THE FULL INITIAL PAYMENT FOR THE GROUP BENEFITS HEREIN IDENTIFIED ON THE CHECKLIST. IT IS UNDERSTOOD THAT THE RATES WILL BE DETERMINED FROM INITIAL ENROLLMENT DATA. IT IS UNDERSTOOD THAT COVERAGE WILL NOT COMMENCE UNTIL THE APPLICATION HAS BEEN APPROVED AND THE CONDITIONS OF COVERAGE ARE ACCEPTED BY THE EMPLOYER.
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### AUTHORIZATION THE FOLLOWING AUTHORIZATION SECTION MUST BE SIGNED

<b>15</b>	THIS IS AN APPLICATION FOR COVERAGE ONLY. NO CONTRACT FOR COVERAGE WILL EXIST UNTIL BLUE SHIELD OF CALIFORNIA HAS COMPLETED ITS REVIEW AND COMMUNICATED TO THE APPLICANT OR THE APPLICANT'S BROKER THAT THE APPLICATION HAS BEEN ACCEPTED AND A GROUP HEALTH SERVICE CONTRACT WILL BE ISSUED.		
	I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF THE RESPONSES GIVEN ABOVE ARE TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT IF I HAVE MISREPRESENTED OR OMITTED ANY MATERIAL FACT, ANY COVERAGE APPROVED BY BLUE SHIELD LIFE MAY BE CANCELLED, THE HEALTH SERVICE CONTRACT/INSURANCE POLICY RESCINDED OR THE APPLICABLE DUES RATE ADJUSTED.		
	AUTHORIZED SIGNATURE	NAME AND TITLE (PLEASE PRINT)	DATE

### PRODUCER INFORMATION (TO BE COMPLETED BY PRODUCER OR GENERAL AGENT)

<b>16</b>	PRODUCER NAME	PRODUCER E-MAIL	PHONE NUMBER (   )	FAX NUMBER (   )
	PRODUCER STREET ADDRESS (P.O. BOX NOT ACCEPTABLE)			IRS REPORTING NUMBER
	CITY	STATE	ZIP	DEPT. OF INSURANCE LICENSE NUMBER
	GENERAL AGENT NAME			GENERAL AGENT E-MAIL
	WOULD YOU PREFER TO BE CONTACTED BY FAX OR EMAIL?		REGION	CODE #
	BLUE SHIELD ACCOUNT EXECUTIVE	PHONE NUMBER (   )	FAX NUMBER (   )	OFFICE NUMBER (   )
	SALES REP # AND REGION		ACCOUNT MANAGER/SERVICE REP. (IF APPLICABLE)	