

HOW TO ENROLL IN THE DENTAL PLAN

Please complete BOTH enclosed applications for your dental coverage. Make sure to fill in the date you wish the coverage to be effective. Please be sure to **sign and date BOTH applications.**

- 1) Fill out the **Group Application** and an **Enrollment Card** for **each person/family** applying for the plan. Make sure to choose a participating dentist.
- 2) Enclose a check for the first month’s premium, payable to:

“Dentecare Delivery Systems, Inc.”

(PLEASE NOTE – *If only (1) person, or (1) Family is applying for this plan, a check to cover a full year’s premium must be included with the application.*)

- 3) Please provide **Proof of Business** – Business Tax Form required- (**Schedule C, K-1, NYS45 or 1099**)
- 4) Also enclose a check for **\$45.00 Payable to “PBBA.”** (This covers The one time enrollment fee of \$10.00 plus the \$35.00 annual dues.) **Please note, that if you are already a PBBA Member, only send the one enrollment fee of \$10.00.**

	<u>1 or 2 Life Groups</u>		<u>3 or more Life Groups</u>
	<u>Low</u>	<u>Medium</u>	<u>High</u>
Employee	\$16.90	\$28.17	\$36.62
Employee & Spouse	\$27.46	\$48.94	\$64.08
Employee & Children	\$27.46	\$48.94	\$64.08
Family	\$38.02	\$69.71	\$91.54

Return BOTH application forms and your (2) checks to the following address:

**The Washwick Agency / PBBA
860 East Main Street
Riverhead, NY 11901
(631) 369 - 0888**

DENTCARE

DELIVERY SYSTEMS, INC.
GROUP DENTAL APPLICATION

EMPLOYER INFORMATION

Company Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____ Title _____ Phone _____

Group Enrollment Census _____ = Single _____ Two Party _____ Family _____ Requested Effective Date ____ / 01 / ____

Has your company ever had dental coverage with Healthplex Insurance Company, Dentcare Delivery Systems, Inc. or International Healthcare Services, Inc.? YES or NO

PLEASE CHECK BILLING PERIOD: MONTHLY QUARTERLY ANNUALLY

PLEASE SELECT A PLAN:

- _____ **CapDent** - Minimum enrollment of 2 employees.
 - _____ **CapDent Plus** - Minimum enrollment of 3 employees.
 - _____ **CapDent Plus Ultra** - Minimum enrollment of 3 employees.
 - _____ **Omni Plan** - 50% participation with a minimum of 3 employees. Groups under 10 employees must submit their most recent NYS - 45 Form.
 - _____ **Comprehensive Voluntary *** - Low _____ Medium _____ High _____ High Enhanced _____
- * Groups with 10 or more employees may offer multiple plans and need not select a single plan. Groups with less than 10 employees must select a single plan. Groups of less than 3 employees may not select the High or High Enhanced Plan. Groups with one employee must select annual billing.

NOTES: 1. Groups selecting the **OMNI** Plan may combine with another plan to reach the required minimum. If applicable, enter the name of the other plan along with the number of employees enrolling in the plan.

Name of Other Plan	# of Enrollees	Policy # (if current Plan)
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2. There is an additional monthly premium of \$10.00 for each family member in excess of five (5).
3. Coverage for all dependents ends at age 19, or age 25, if full-time student.
4. Application, enrollment cards and payment must be received by the 15th of the month for coverage to begin on the first of the next month. Exceptions will only be made if the application is received between the 15th and the 25th of the current month and payment is made by direct debit, certified check, money order, credit card or wire transfer.
5. This application is subject to its acceptance in writing by Dentcare Delivery Systems, Inc.

Please make all remittances payable to: **Dentcare Delivery Systems, Inc.**

SIGNATURE OF OFFICER	TITLE	DATE
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BROKER/AGENT: Karl Washwick

COMPANY: The Waswick Agency Inc.

ADDRESS: 860 East Main St., Riverhead STATE: NY ZIP: 11901

PHONE: 631-369-0888 S.S. # /TAX ID #: _____

GROUP #: _____ SALES REP: _____

333 Earle Ovington Boulevard, Suite 300, Uniondale, NY 11553-3608
1-800-468-0466 * Fax 516-228-9572 * Website: www.dentcaredeliverysystems.org

