Anthem BlueCross BlueShield

2015 Staples Mill Road
PO Box 27401
Richmond, VA 23279

Master Dental Contract Application Pooled Programs

PART A – COMPANY INFORMATION:

Legal Company Name _____

Address _____ Phone ( ) _____

_____

City _____ State _____ Zip Code _____

Plan Effective Date: _____ Federal Tax ID#: _____

Eligibility probationary period for new employees: First of month following: _____ Other: _____

Type of Coverage: ☐ Employee Only ☐ Employee and Dependents

Does your company currently have a dental plan? ☐ No ☐ Yes (name of carrier): _____

(Attach copy of most recent billing statement & benefit summary) Length of coverage: _____

PART B – ELIGIBLE EMPLOYEES:

Total number of eligible employees _____

PART C – DENTAL PROGRAM (choose one):

☐ Prime ☐ Complete

PART D – VOLUNTARY PLANS:

☐ **ANTHEM VOLUNTARY**

Select Plan Design ☐ Active ☐ Passive **Select Annual Deductible** ☐ $25/75 ☐ $50/150

Select Annual Maximum ☐ $1,000 ☐ $1,500 **Annual Maximum Carryover** ☐ Yes ☐ No

Select Orthodontic Coverage (A minimum of 10 employees must enroll)

☐ 50% coverage for dependent children; Lifetime maximum to match annual maximum.

☐ No Coverage

Participation: A minimum of five (5) employees must enroll.

PART E – EMPLOYER PAID PARTICIPATION:

☐ 2-4 Eligible Employees: 100% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll.

☐ 5-99 Eligible Employees: A minimum of 60% of employees not covered by another dental plan (and a minimum of two) are required to enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two options and the two plans offered must have at least a 20% premium differential.

☐ Medical Lock (Packaged Enrollment): All members enrolled in the group's medical plan must enroll in Anthem dental. The medical plan billing must be included with new group submission materials. Dental tiering must be identical on the medical and dental plans regardless of medical carrier. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

PART F – EMPLOYER PAID PLANS:

☐ **ANTHEM VALUE**

Select Plan Design ☐ Active ☐ Passive **Select Annual Maximum** ☐ $500 ☐ $1,000 **Deductible** $50/$150 Annual

☐ **ANTHEM CLASSIC**

Select Plan Design ☐ Active ☐ Passive **Select Annual Deductible** ☐ $25/75 ☐ $50/150

Select Annual Maximum ☐ $1,000 ☐ $1,500 **Annual Maximum Carryover** ☐ Yes ☐ No

Select Benefit Category for Endodontic, Periodontal & Oral Surgery ☐ Basic ☐ Major

Select Orthodontic Coverage (A minimum of 10 employees must enroll.)

- ☐ 50% coverage for adults and dependent children; Lifetime maximum to match annual maximum.
- ☐ 50% coverage for dependent children; Lifetime maximum to match annual maximum.
- ☐ No Coverage

☐ **ANTHEM ENHANCED**

Select Plan Design ☐ Active ☐ Passive **Select Annual Deductible** ☐ $25/75 ☐ $50/150

Annual Maximum $2,000 **Annual Maximum Carryover** ☐ Yes ☐ No

Select Orthodontic Coverage (A minimum of 10 employees must enroll.)

- ☐ 50% coverage for adults and dependent children; Lifetime maximum to match annual maximum.
- ☐ 50% coverage for dependent children; Lifetime maximum to match annual maximum.
- ☐ No Coverage

PART G – RATES SOLD:

Employee only $	Employee + Spouse $	Employee + Child(ren) $	Family $
Employee only $	Employee + Spouse $	Employee + Child(ren) $	Family $

PRODUCER OF RECORD (if any) Completion of all fields required:

Name _____ Agency _____

Address _____ Phone ( ) _____

City _____ State _____ Zip Code _____

E-mail Address _____ _____

Tax ID Number

_____

Producer Signature/Insurance Producer License ID #

GENERAL AGENT (if any) Completion of all fields required:

Name _____ Agency _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

E-mail Address _____ _____

G.A.'s Tax ID Number

PREMIUM REMITTANCE AND SUBMISSION:

A check for the first month's premium payable to Anthem must accompany the application. Thereafter, the monthly premium payment along with the corresponding statement or invoice must be received by the first of each month. Contact your broker or your Anthem Sales Representative with questions.

1. Select Payment Option:
   ☐ ACH - Include ACH Authorization Form and voided check
   ☐ CHECK ☐ WIRE
2. Complete application. Retain a copy for your files.
3. Each eligible employee must complete and sign a Membership Enrollment Form or be identified on an approved Enrollment spreadsheet completed by Group Administrator.
4. Send the original Master Application, completed Membership Enrollment Forms or approved Enrollment spreadsheet, check for first month's premium, corresponding Dental Proposal(s), and prior billing statement and benefit summary, if applicable, to your broker or your Anthem Sales Representative.

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Anthem dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two.

Anthem dental will send a contract upon acceptance of the application. The contract will indicate the effective date of coverage. The contract is effective only after Anthem dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Anthem dental.

SIGNATURE BOX:

Signature of Authorized Company Official	Title	Date
Group Administrator/Future Correspondence Contact (please print)		Title
( )	( )	
Phone Number	Fax Number	E-mail Address