California Dental Network
Where Experience Makes The Difference
1971 E. 4th Street, Suite 184 ♦ Santa Ana ♦ CA 92705 ♦ Phone (714) 479-0777, Toll-Free (877) 4-DENTAL (433-6825) ♦ Fax (714) 479-0779
www.caldental.net, e-mail **marketing@caldental.net**

GROUP APPLICATION

GROUP INFORMATION

GROUP NAME_____

ADDRESS_____
STREET ADDRESS SUITE NUMBER CITY STATE ZIP CODE

CONTACT PERSON INFORMATION_____
NAME TITLE PHONE & FAX

TYPE OF ENTITY: _____CORPORATION _____PARTNERSHIP _____SOLE PROPRIETORSHIP _____ASSOCIATION

_____OTHER (PLEASE SPECIFY)_____

NATURE OF BUSINESS_____

IS THIS PLAN INTENDED TO REPLACE EXISTING COVERAGE? _____YES _____NO WAITING PERIOD? _____YES _____NO

IF SO, WHAT TYPE? _____HMO _____INDEMNITY _____PPO LIMITS_____

PRESENT CARRIER_____
NAME POLICY NUMBER EFFECTIVE DATE OF COVERAGE TERMINATION DATE

PLEASE INCLUDE A COPY OF THE PRIOR CARRIER'S BENEFIT BOOKLET AND A COPY OF THE LAST BILLING.

NUMBER OF ELIGIBLE EMPLOYEES/MEMBERS_____ NUMBER OF ELIGIBLE DEPENDENTS_____

IF ALL EMPLOYEES/MEMBERS ARE NOT ELIGIBLE, PLEASE EXPLAIN_____

IS ENROLLMENT VOLUNTARY? _____YES _____NO EMPLOYER CONTRIBUTION: _____% EMPLOYEE _____% DEPENDENT

IF ENROLLMENT IS NOT VOLUNTARY, PLEASE INCLUDE A FORM DE-6, QUARTERLY WAGE & WITHHOLDING REPORT.

PLAN INFORMATION

SELECT PREPAID PLAN:

PLAN 303 _____
PLAN 404 _____
PLAN 505 _____
PLAN 460 _____
OTHER _____

	RATES		# ENROLLED		TOTALS
SINGLE	$_____	x	_____	=	$_____
COUPLE	$_____	x	_____	=	$_____
FAMILY	$_____	x	_____	=	$_____

MONTHLY PREMIUM TOTAL ..... $_____

ONE-TIME NON-REFUNDABLE ENROLLMENT FEE ($5.00 PER ENROLLEE TO A MAXIMUM OF $50) ..... $_____

MONTHLY BILLING/ADMINISTRATION FEE ..... $ 10.00

TOTAL FIRST MONTH'S REMITTANCE (PLEASE MAKE CHECKS PAYABLE TO **CALIFORNIA DENTAL NETWORK**) ..... $_____

SIGNATURES

The above coverage is hereby requested with an effective date of _____.

Employer_____ Date_____
Authorized Representative or Corporate Officer

Writing Agent DelPacific Insurance Services Agent # 1593 Date_____