

DENTAL PREMIUM / MONTHLY COST

Select one tier structure:

Option A:

- Composite rate: \$ _____
- Two tier rates: Single: \$ _____ Family: \$ _____
- Three tier rates: Single: \$ _____ EE& One Dependent: \$ _____ Family: \$ _____
- Four tier rates: Single \$ _____ EE&Spouse \$ _____ EE/Child(ren): \$ _____ Family: \$ _____
- Five tier rates: Single: \$ _____ EE&Spouse: \$ _____ EE& 1 Child: \$ _____ EE&Children: \$ _____ Family: \$ _____
- Five tier rates: Single \$ _____ EE&Spouse \$ _____ EE& 1 Child \$ _____ EE&2 or 3 deps \$ _____ EE&4or more deps \$ _____

Option B:

- Composite rate: \$ _____
- Two tier rates: Single: \$ _____ Family: \$ _____
- Three tier rates: Single: \$ _____ EE& One Dependent: \$ _____ Family: \$ _____
- Four tier rates: Single \$ _____ EE&Spouse \$ _____ EE/Child(ren): \$ _____ Family: \$ _____
- Five tier rates: Single: \$ _____ EE&Spouse: \$ _____ EE& 1 Child: \$ _____ EE&Children: \$ _____ Family: \$ _____
- Five tier rates: Single \$ _____ EE&Spouse \$ _____ EE& 1 Child \$ _____ EE&2 or 3 deps \$ _____ EE&4or more deps \$ _____

Option C:

- Composite rate: \$ _____
- Two tier rates: Single: \$ _____ Family: \$ _____
- Three tier rates: Single: \$ _____ EE& One Dependent: \$ _____ Family: \$ _____
- Four tier rates: Single \$ _____ EE&Spouse \$ _____ EE/Child(ren): \$ _____ Family: \$ _____
- Five tier rates: Single: \$ _____ EE&Spouse: \$ _____ EE& 1 Child: \$ _____ EE&Children: \$ _____ Family: \$ _____
- Five tier rates: Single \$ _____ EE&Spouse \$ _____ EE& 1 Child \$ _____ EE&2 or 3 deps \$ _____ EE&4or more deps \$ _____

Will the employees be required to contribute toward the cost of the insurance? Yes No

If yes, indicate the percentage of the cost of each coverage the employee will pay.

Coverage	EE Dental	Dep Dental
Employee % or Dollar amount		

Note: If the employer pays the entire cost for the **employees**, then 100% of the eligible employees **must** apply for coverage.

DENTAL COVERAGE INFORMATION

Employee Plan Option A: _____

Select One

	Benefit Waiting Period	Deductible Amount per Person (check one)	<input type="checkbox"/> Indemnity Coinsurance Percentage	<input type="checkbox"/> PPO Coinsurance Percentage In Network/Out of Network
Preventive Care	_____	<input type="checkbox"/> Annual <input type="checkbox"/> Lifetime	_____	_____
Diagnostic Care	_____	_____	_____	_____
Basic Care	_____	_____	_____	_____
Major Care	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____

Office Visit Co-pay: \$ _____

Other Co-pays \$ _____ Applied to: _____

Dental Maximum (except ortho) Calendar Year Plan Year Amount _____

Orthodontics Yes No If Yes, Calendar Year Limit \$ _____ Lifetime Maximum \$ _____

Dental PPO Yes No Network _____

Optional Benefits (additional premium may be required)

Deductible credit/Annual maximum credit (only available on calendar year plans): Yes No

Posterior Composites (this box needs to be checked and additional premium paid to add this coverage) Yes

Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage) Yes

Coverage for Veneers (this box needs to be checked and additional premium paid to add this coverage) Yes

Employee Plan Option B: _____

Select One

	Benefit Waiting Period	Deductible Amount per Person (check one)	<input type="checkbox"/> Indemnity Coinsurance Percentage	<input type="checkbox"/> PPO Coinsurance Percentage In Network/Out of Network
Preventive Care	_____	<input type="checkbox"/> Annual <input type="checkbox"/> Lifetime	_____	_____
Diagnostic Care	_____	_____	_____	_____
Basic Care	_____	_____	_____	_____
Major Care	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____

Office Visit Co-pay: \$ _____

Other Co-pays \$ _____ Applied to: _____

Dental Maximum (except ortho) Calendar Year Plan Year Amount _____

Orthodontics Yes No If Yes, Annual Limit \$ _____ Lifetime Maximum \$ _____

Dental PPO Yes No Network _____

Optional Benefits (additional premium may be required)

Deductible credit/Annual maximum credit (only available on calendar year plans): Yes No

Posterior Composites (this box needs to be checked and additional premium paid to add this coverage) Yes

Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage) Yes

Coverage for Veneers (this box needs to be checked and additional premium paid to add this coverage) Yes

