

# NEW BUSINESS SUBMISSION FORM

## Policy Administration Information

The following information needs to be completed in order to assist IHC Health Solutions in administering your dental plan. Please place a check mark in the appropriate box or circle where indicated.

Employer Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Employer E-mail Address: \_\_\_\_\_

Agent E-mail Address: \_\_\_\_\_

### INITIAL ENROLLMENT PROCESS

*Employer wishes to submit initial enrollments as follows (check one):*

- Online enrollment via the Internet (IHC Health Solutions will advise password).  
 Submit hardcopy enrollments to **IHC Health Solutions** or **Agent** (circle one) (IHC HS to provide forms).

### ONGOING ENROLLMENT PROCESS

*Employer wishes to submit ongoing enrollments as follows (check one):*

- Online enrollment via the Internet (IHC Health Solutions will advise password).  
 Submit hardcopy enrollments to **IHC Health Solutions** or **Agent** (circle one) (IHCHS to provide forms).

### ADMINISTRATION KITS (WELCOME TO IHC HEALTH SOLUTIONS)

*IHC Health Solutions to forward the Administration Kit and Instruction Guide as follows (check or circle as indicated):*

- Send via the Internet to Agent or Employer (circle one).  
(above information will be E-mailed within 2 business days of receipt of completed requirements)  
 Send hardcopy directly to **Agent** or **Employer** (circle one).

### DENTAL INSURANCE POLICY AND CERTIFICATES

*IHC Health Solutions to forward the Policy and Certificates as follows (check or circle as indicated):*

- Send via the Internet to Agent or Employer (circle one).  
(above information will be E-mailed within 5 - 15 working days of receipt of all completed requirements)  
 Send hardcopy directly to **Agent** or **Employer** (circle one).

**Note:** Based on Insurance Regulations, it is required that the Employer provide the Insurance Certificates to the Employees either as a hardcopy or through online access.

The undersigned acknowledges the above instructions and understands the importance of providing the Employees the Insurance Certificates immediately upon receipt.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date

Return These Forms to:  
**Northwest Marketing Resources, Inc.**

Regular Mail:

PO Box 447, Olympia WA 98507

Next Day:

1427 4th Ave E, Olympia WA 98506



# NEW BUSINESS SUBMISSION FORM

## Agent Information

### NEW BUSINESS SUBMISSION CHECKLIST

Please make sure the following is submitted with **all** new cases. We cannot process a case without all of the following information:

- Completed Employer Application
- Completed Employee Enrollments
- 1<sup>st</sup> Month Premium Payable to IHC Health Solutions
- Section 125 Plan Verification, if any
- Producer Licensing Forms (if not previously submitted)
- Verification of Eligibility Form
- Copy of Quoted Rates
- Completed Submission Form

### TAKE OVER CREDIT CASES

Please make sure **all** of the following information is enclosed on all prior coverage take over cases:

- Copy of prior plan schedule of benefits and rates
- Copy of prior plan's last billing listing each employee covered.

**\*\*Prior credit is available only to Employees enrolled on the initial effective date of the plan and approved by IHC Health Solutions.**

### GUIDELINES AND PROCEDURES

1. All coverage will be effective on the first of the month, except when necessary for takeover cases. All groups with initial effective dates other than the 1<sup>st</sup> of the month will be converted to the 1<sup>st</sup> of the month and will become the anniversary date.
2. Voluntary Groups. Payroll deductions should begin 4-6 weeks prior to effective date in order to satisfy premium prior to the effective date.
3. In no event will claims be paid prior to the effective date *and* the date group setup is complete.
4. Applications, premium and enrollment forms must be received **before** the requested effective date month.
5. Upon receipt of *complete* documentation, IHC Health Solutions will assign a group number and issue an administration folder to the Employer. I.D. cards and certificates will follow.

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# Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number \_\_\_\_\_  
 Group Number \_\_\_\_\_
2. Total number of employees on payroll \_\_\_\_\_
3. Total number of employees working 1-29 hours per week (include temporary and/or seasonal employees) \_\_\_\_\_
4. Total number of employees in waiting period \_\_\_\_\_
5. Number of full-time eligible employees (subtract numbers 3 and 4 from number 2) \_\_\_\_\_

If you have purchased an employee paid voluntary group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above. No waivers for coverage under another program will be allowed in this calculation.

For employer paid group coverage (with rates calculated from a census), the number of employees listed in number 6 and 7 below may be subtracted from the number of full time employees shown in number 5 above. Participation requirements will be calculated from that number.

6. Total number of employees enrolled in a DHMO or qualified Discount/Referral plan (proof must be submitted) \_\_\_\_\_
7. Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file) \_\_\_\_\_
8. Number of eligible employees (subtract 6 & 7 from 5) \_\_\_\_\_
9. Number of full-time employees enrolled \_\_\_\_\_
10. Premium information: \_\_\_\_\_ 100% employer paid **OR** employer pays \_\_\_\_\_% of employee premium and \_\_\_\_\_% of dependent premium.

### Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by IHC Health Solutions, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

Signature of Writing Agent \_\_\_\_\_ Agent Code \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Type or Print Agent's Name(s) \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Agent's Business Address (City, State & Zip Code) \_\_\_\_\_

Title \_\_\_\_\_

Agency \_\_\_\_\_ Agency Code \_\_\_\_\_

Company Name \_\_\_\_\_





**DENTAL PREMIUM / MONTHLY COST**

**Select one tier structure:**

- 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 depts \$ \_\_\_\_\_ EE&4or more depts \$ \_\_\_\_\_

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

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

**Optional Benefits (additional premium may be required)**

Deductible credit/Annual maximum credit (only available on calendar year plans):  Yes

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

~~Cosmetic Procedures — Teeth Whitening (this box needs to be checked and additional premium paid to add this coverage)  Yes~~

~~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~~

**AS THE UNDERSIGNED EMPLOYER:**

**PREMIUM PAYMENT:** I understand and agree that I am responsible for making the proper monthly premium payments. Furthermore, it is understood that a grace period of thirty-one (31) days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the thirty-one (31) day grace period, coverage for all Covered Persons shall lapse as of the premium due date. Any negotiable premium checks received in an envelope postmarked after the thirty-one (31) day grace period will be refunded less any amounts due (if any) from previous months.

**MY ANSWERS ARE TRUE AND CORRECT:** I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my employees. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any questions. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

**MINIMUM EMPLOYEE/DEPENDENT PARTICIPATION REQUIREMENTS:** I also understand that if I am unable to maintain any minimum employee participation under the employer plan, then coverage may cease.

I agree and understand the insurance coverage which is to be placed in force is subject to all of the provisions of the group policy, including, without limitation to the foregoing, the right of the Insurance Company to periodically request and inspect payroll and personnel records which may have a bearing on or be the basis for any insurance coverage requested, placed in force, or maintained.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Writing Agent                      Agent Code                      Applicant's Signature

\_\_\_\_\_  
Signature of Other Agent(s)                      Agent Code                      Type or Print Applicant's Name

\_\_\_\_\_  
Agency Name                      Agent's Phone Number

\_\_\_\_\_  
Agent's Business Address                      City                      State                      Zip

**SPECIAL REQUESTS**

Send Administration Kit, Certificates, and ID Cards to:  Broker     Employer

General Agency : Northwest Marketing Resources, Inc.

**MADISON NATIONAL LIFE INSURANCE COMPANY, INC.**

**EMPLOYEE DENTAL INSURANCE APPLICATION**

PLEASE PRINT IN SPACE PROVIDED

<b>EMPLOYER INFORMATION</b>					
EMPLOYER NAME			LOCATION		GROUP NO.
<b>EMPLOYEE</b>					
LAST NAME		FIRST NAME			M.I.
STREET ADDRESS		CITY	STATE		ZIP
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ( )			BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
<b>COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only)</b>					
<u>Dental Insurance</u>					
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN      REQUESTED EFFECTIVE DATE: _____					
<b>DEPENDENT INFORMATION</b>					
SPOUSE NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: _____					
<b>REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent</b>					
I DECLINE DENTAL COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILDREN					
REASON FOR REFUSAL: _____					
<b>ACKNOWLEDGMENT AND AUTHORIZATION</b>					
I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.					
WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.					
DATE		CITY AND STATE			
SIGNATURE OF EMPLOYEE					