Send Completed Form To:
Healthplex Insurance Company
333 Earle Ovington Blvd., 3rd Floor
Uniondale, New York 11553-3608
P 800-468-0466 • F 516-228-9572
www.healthplex.com

Healthplex Insurance Company Plan Group Application

Employer Information

Company Name			Group #	
Address	Suite #	City	State	Zip Code
Contact Person	Title		Phone	

Group Enrollment Census				Email Address:	Effective Date
Single	Two Party	Family	Total Enrollment	_____@_____	

Monthly Premium Rates

Single:$_____ Two Party:$_____ Family:$_____

Payment Options

Check

Check enclosed in the amount of $_____ payable to Healthplex Insurance Company representing initial month's premium.

Credit Card - An additional $5.00 processing fee will be added to any credit card charge.

☐ Visa (or) ☐ Mastercard → ☐ Initial monthly charge ☐ Recurring monthly charge (check one or both)

Name on Card_____

Card Number_____Exp. Date_____

Direct Debit

☐ Direct Debit **Allow 30 days for processing. First payment must be made by check.*

Routing Number	Account Number
Financial Institution	
Name on Account	

Checklist of Enclosures

☐ Signed Group Application.
☐ Most recent NYS-45 Quarterly Tax Report.
☐ HIC Group Enrollment form(s) for each employee.
☐ Initial monthly premium payment by check (enclosed) or credit card.
☐ Enrollment data provided electronically, if applicable.

By signing below, I acknowledge that I have read and agree to the terms and conditions on the reverse side.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date

Broker Information

Broker/Agent	Company Name	SSN/Tax ID#
Broker/Agent	Company Name	SSN/Tax ID#

(OVER)

Dental Plan Details

Network	In-Network	Out-of-Network	Annual Maximum	Orthodontia
☐ Metro	☐ 100/100/100	☐ Fee ☐ 80%UCR	☐ $1,000	☐ Yes
☐ Liberty	☐ 100/100/50	☐ 100/100/100	☐ $1,250	☐ No
☐ Capital	☐ 100/80/50	☐ 100/100/50	☐ $1,500	**Ortho Lifetime Maximum**
☐ Capital Plus	☐ 100/80/0	☐ 100/80/50	☐ $2,000	☐ None
☐ Other	☐ 80/80/80	☐ 100/80/0	☐ $2,500	☐ $500
Fee Schedule	☐ 50/50/50	☐ 80/80/80	☐ $3,000	☐ $1,000
☐ 14C	☐ 90/70/40	☐ 50/50/50	☐ Other	☐ Other
☐ 26A	☐ 90/70/20	☐ 90/70/40	**Deductible**	**Group Number**
☐ 4A	☐ 80/60/40	☐ 90/70/20	☐ No Deductible	
☐ 28A	☐ Other	☐ 80/60/40	☐ $25/$75	
☐ Other		☐ Other	☐ $50/$150	
			Waive Deductibles ☐ Yes ☐ No	

Supplemental/Additional Information (Internal Use Only)

Age Limits	Age Ends on	Ortho Age	End of Calendar Year
_____ /_____	☐ Birthday ☐ End of Month		☐ Yes ☐ No ☐ End of Month

Benefits are per: ☐ Contract Year ☐ Calendar Year	Assignment of Benefits: ☐ Yes ☐ No
Billing Period: ☐ Monthly ☐ Quarterly ☐ Annually	Billing Format: ☐ Paper ☐ Email ☐ FTP
Term of Agreement: ☐ 12 ☐ 24 ☐ 36	Days to Renew: ☐ 30 ☐ 60 ☐ 90
	Claims Group

Vision

☐ VO - No Vision ☐ V1 - Affinity Hybrid ☐ V2 - Comprehensive Funded I

☐ V3 - Comprehensive Funded II ☐ V4 - Designer Materials ☐ V5 - Comprehensive Funded - Vol ☐ VV - Embedded

Major Service Waiting Periods	Healthplex Account Representative	
☐ None ☐ 12 Months ☐ 24 Months		

Terms and Conditions

Dental Plan Information

This plan is underwritten by Healthplex Insurance Company. The Group Dental Agreement can be found on the Healthplex, Inc. (Third Party Administrator) website. A hard copy is available upon request. It is understood and agreed that all benefit levels, exclusions and limitations are detailed in the Certificate of Insurance, and the general provisions of this Agreement are detailed in the General Dental Agreement. It is further understood that, upon the applicant signing this application and upon its acceptance by Healthplex Insurance Company, the Group Dental Agreement is binding between the applicant and Healthplex Insurance Company.

Minimum Participation Requirement

The group agrees to maintain a minimum of three (3) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.

Payment Authorization

Should recurring payment of monthly premium be made through the credit or debit card option, the group authorizes Healthplex Insurance Company to charge its corporate credit or debit card automatically each month on a recurring basis for the 12-month period. Should payment be made through direct debit, the group authorizes Healthplex Insurance Company to directly debit the designated bank account each month.

Cancellation Policy

If dental coverage lapses due to non-payment of premium, it is understood that the group's policy will be terminated in accordance with NYS insurance law.

Renewal Conditions

The group is aware that this dental plan is an annual policy. Upon renewal, Healthplex Insurance Company reserves the right to change monthly premium rates.

(OVER)