Attestation

Group Information

_____
Group Name

A. Employer Premium % Contribution *

Please indicate the total number of employees and the employer contribution toward the following employee classifications below.

Classification	Employer % Contribution	Total # of Employees
Single		
Two Party		
Family		

**Must attach a copy of the most recent quarterly NYS-45.*

B. Gender

Please list the total number of employees enrolling and the breakdown by gender.

Male	
Female	
Total	

C. Prior Coverage**

Please indicate your group's prior coverage with another dental insurance carrier and the length of such coverage:

_____ _____
Prior Insurer Length of Coverage

***Must attach proof of prior dental insurance coverage (i.e. most recent vendor invoice).*

I, _____, _____ (Name,Title), hereby certify that the information contained herein for the period _____ (Indicate Contract Year), is accurate, complete and truthful. I understand and agree that any misrepresentation concerning this information will constitute a breach of my agreement with (Healthplex, Inc.), (Healthplex Insurance Company), (Dentcare Delivery Services, Inc.), (International Healthcare Services) and will result in the immediate termination of my group's policy.

_____ _____
Signature Date

_____
Name

_____
Title

If you have any questions or need assistance, please contact the Sales & Marketing Department at 800 468-0466.
Please return completed form to:

Attn: Sales & Marketing
Healthplex, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553-3608

HEALTHPLEX
THE DENTAL BENEFIT EXPERTS