

Buy-Up Dental Application



721 S. Parker, Suite 200,
Orange, CA 92868

Group Name	Contact Name
Group Number	Phone #
Requested Effective Date*	Fax #

*For plans 1000, 3000, 3500, 4000, and 5000, application must be completed by the 25th prior to effective date.

Step 1: Select one plan offering:

- All buy-up dental plans: Prepaid 1000 & 3000, EPO 3500*, and PPO 4000* & 5000* WITHOUT Ortho*
- All buy-up dental plans: Prepaid 1000 & 3000, EPO 3500*, and PPO 4000* & 5000* WITH Ortho*
**PPO plans with Ortho are only available to groups with 5 or more eligible employees*
- Voluntary 3000 and FDH Access 100
- FDH Access 100 only

Groups electing 3500, 4000 or 5000 with 10 or more employees qualify for takeover benefits by submitting the following: 1) Group's most recent prior dental billing statement; 2) Statement from 12 months prior to effective date; 3) and 24 months prior showing Ortho for Ortho takeover

Step 2: Complete numbers 1-6 below:

1. Total number of employees applying for dental coverage: _____
2. Total number of COBRA eligibles applying for dental coverage: _____
3. Percentage of employee-only premium paid by Employer: _____ % *(Employer must pay a minimum of 50%)*
4. Percentage of dependent premium paid by Employer: _____ % *(write 0 if none)*
5. Employer contribution is based on plan: 1000 3000 3500 4000 5000 *(Check one box only.)*
6. Does your group currently have dental? Yes No If yes, carrier name: _____

Guidelines and Requirements

Participation Requirements

- 100% Employer Contribution: 70% of all eligible employees must enroll (including waivers)
- 50%-99% Employer Contribution: 70% of all employees minus those waiving due to "other GROUP dental" coverage

Takeover policy for Dental 3500, 4000 and 5000

- Groups with 2-9 eligible employees are subject to a 12 month waiting period for major services. 24 months for Ortho Benefit.
- Groups with 10+ eligible employees may apply prior coverage credit towards the waiting period by submitting the following:
 - 1) **Prior dental carrier's most recent billing statement**
 - 2) **Billing statement from 12 months prior (or less if coverage in force for less time). 24 months for Ortho Benefit.**

Employer and Dependent Coverage Information

- Enrollment applications required for employees and dependents not currently enrolled with CaliforniaChoice.
- Waivers required for employees and dependents not enrolling for new dental coverage (initial waivers no longer valid).
- Employees electing 1000 or 3000 must select a dentist
- Coverage codes*: **EE=Employee only** **ES=Employee & Spouse** **EC=Employee & Children** **EF=Employee & Family**
- If any currently enrolled employees have terminated, please complete the "Termination Form."

Employee's Full Name	Coverage Code	Plan	Dentist/Dental Office (Plans 1000/3000 only)	Dentist I.D. #
<i>Example: John Smith</i>	<i>EC</i>	<i>3000</i>	<i>Bill Jones</i>	<i>DP65-00</i>
1.				
2.				
3.				
4.				
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10.				
11.				
12.				
13.				
14.				

Employer Signature _____

Employer Print Name _____

Date _____

Please make a photocopy if additional forms are necessary

CC 0566 05/2003