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Master Application Checklist

To ensure efficient turnaround time, please use this checklist to confirm commonly missed information when submitting a new pooled group.

MASTER DENTAL CONTRACT APPLICATION

Part A – Company Information

- ☐ Coverage type. If 'employee-only' is selected, dependent coverage will not be available to current and future employees.
- ☐ Eligibility waiting period for new eligible employees (probationary period).

Does your company currently have a dental plan? If yes, please include the following:

- ☐ Current billing statement.
- ☐ Copy of current plan summary/benefit page to verify comparable coverage if replacing dental plan.
- ☐ Indicate length of coverage with current dental carrier.

Part B – Eligible Employees

- ☐ Indicate total number of eligible employees (defined as employees working 30 or more hours per week).

Part C – Dental Program

- ☐ Indicate selected program: Prime or Complete.

Part D – Voluntary Plans

- ☐ Indicate plan design selected.
- ☐ Indicate deductible and maximum selected.
- ☐ Indicate orthodontia, if selected by group.

Part E – Employer Paid Participation

- ☐ Indicate Participation requirements selected.

Part F – Employer Paid Plans

- ☐ Indicate plan design selected.
- ☐ Indicate deductible and maximum selected (if applicable).
- ☐ Indicate orthodontia, if selected by group.

Part G – Rates Sold

- ☐ Enter rates sold in all applicable fields. Must include copy of proposal(s) with new group materials.

Premium Remittance and Submission

- ☐ Indicate Automatic Check Handling (ACH) or monthly payment by check.
- ☐ If selecting ACH, include ACH Authorization Form and voided check
- ☐ If selecting monthly billing, no binder check needed. Group will be billed 2 months premium on first bill.

Enrollment Forms

- ☐ Verify all employee information (Social Security Number, date of birth, address, etc.) is legible.
- ☐ Part B must be completed. If waiving coverage for employees and /or any eligible family member.
- ☐ Part D must be completed and signed. If dependents have other coverage, please include policy number/name.
- ☐ Signatures as required.
- ☐ Please complete all required fields and print clearly.
- ☐ Part E – Complete all applicable fields, including Group Name.

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370 Bassett Road
North Haven, CT 06473

Master Dental Contract Application Pooled Programs

PART A – COMPANY INFORMATION:

Legal Company Name ______________________________

Physical Address ______________________________ Phone ______________________________

____

City ______________________________ State ____________ Zip Code ____________

Plan Effective Date: ______________________________

Eligibility probationary period for new employees: First of month following: ______________ Other: ______________

Type of Coverage: ☐ Employee Only ☐ Employee and Dependents

Does your company currently have a dental plan? ☐ No ☐ Yes (name of carrier) ______________________________

(Attach copy of most recent billing statement) Length of coverage: ______________________________

PART B – ELIGIBLE EMPLOYEES:

Total number of eligible employees:

PART C – DENTAL PROGRAM (choose one):

☐ Prime ☐ Complete

PART D – VOLUNTARY PLANS:

☐ **ANTHEM VOLUNTARY**

Select Plan Design ☐ Active ☐ Passive **Select Annual Deductible** ☐ $25/75 ☐ $50/150

Select Annual Maximum ☐ $1,000 ☐ $1,500 **Annual Maximum Carryover** ☐ Yes ☐ No

Select Orthodontic Coverage (A minimum of 10 employees must enroll)

☐ 50% coverage for dependent children; Lifetime maximum to match annual maximum.
☐ No Coverage

Participation: A minimum of five (5) must enroll.

PART E – EMPLOYER PAID PARTICIPATION:

☐ 2-50 Eligible Employees: A minimum of 60% of employees not covered by another dental plan are required to enroll. A minimum of two (2) must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of 5 employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.

☐ Medical Lock (Packaged Enrollment): All members enrolled in any medical plan must enroll in Anthem dental. The medical plan billing for all medical carriers must be included with new group submission materials. Dental tiering must be identical on the medical and dental plans regardless of medical carrier. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

PART F – EMPLOYER PAID PLANS:

☐ ANTHEM VALUE

Select Plan Design ☐ Active ☐ Passive **Select Annual Maximum** ☐ $500 ☐ $1,000 **Deductible** $50/$150 Annual

☐ ANTHEM CLASSIC

Select Plan Design ☐ Active ☐ Passive **Select Annual Deductible** ☐ $25/75 ☐ $50/150

Select Annual Maximum ☐ $1,000 ☐ $1,500 **Annual Maximum Carryover** ☐ Yes ☐ No

Select Benefit Category for Endodontic, Periodontal & Oral Surgery ☐ Basic ☐ Major

Select Orthodontic Coverage (A minimum of 10 employees must enroll.)

- ☐ 50% coverage for adults and dependent children; Lifetime maximum to match annual maximum.
- ☐ 50% coverage for dependent children; Lifetime maximum to match annual maximum.
- ☐ No Coverage

☐ ANTHEM ENHANCED

Select Plan Design ☐ Active ☐ Passive **Select Annual Deductible** ☐ $25/75 ☐ $50/150

Annual Maximum $2,000 **Annual Maximum Carryover** ☐ Yes ☐ No

Select Orthodontic Coverage (A minimum of 10 employees must enroll.)

- ☐ 50% coverage for adults and dependent children; Lifetime maximum to match annual maximum.
- ☐ 50% coverage for dependent children; Lifetime maximum to match annual maximum.
- ☐ No Coverage

PART G – RATES SOLD:

Employee:	Employee + One	Family
$	$	$

PRODUCER OF RECORD (if any) Completion of all fields required:

Name ______________________ Agency ______________________

Address ______________________ Phone ______________________

City ______________________ State __________ Zip Code __________

E-mail Address ______________________ ______________________

Tax ID Number

____

Producer Signature / Insurance Producer License ID #

PREMIUM REMITTANCE AND SUBMISSION:

Anthem dental will bill for the first month's premium. Thereafter, the monthly premium payment along with the corresponding statement or invoice must be received by the first of each month. Contact 203-234-5249 or your Anthem Sales Rep with questions.

1. Select Payment Option:
   ☐ ACH - Include ACH Authorization Form and voided check
   ☐ CHECK ☐ WIRE
2. Complete application. Retain a copy for your files.
3. Each eligible employee must complete and sign a Membership Enrollment Form.
4. Send the original application, completed Membership Enrollment Forms and corresponding Dental Proposal(s) to:

   Anthem Blue Cross and Blue Shield
   370 Bassett Road
   North Haven, CT 06473
   [Attention: B3-F3/Sales Rep Name]

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Anthem dental if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two.

Anthem dental will send a contract upon acceptance of the application. The contract will indicate the effective date of coverage. The contract is effective only after Anthem dental has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Anthem dental.

SIGNATURE BOX:

Signature of Authorized Company Official	Title	Date
Group Administrator/Future Correspondence Contact (please print)		Title
( ) Phone Number	( ) Fax Number	Email Address

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