PARTICIPATING UNIT PAGE
Group Form 2014

1. **Dental Practice Name:** _____

2. **Office Address:** _____ **3. Phone #:** _____

City/State/Zip _____ **4. Fax #:** _____

5. **Insurance Contact:** _____

6. **E-mail:** _____ **IDA Use Only**: IDA Member: Yes No

7. **Employees are eligible for health insurance if they work a minimum of _____ hours per week. (Lowest= 20)**

Every employee working the minimum hours per week stated above must complete an application.
Employees who elect to waive coverage only need to complete Sections 2, 5, and 11.

8.

1 Total Part-time and Full-time employees (including dentist/owner)	
2 Total Eligible employees (including dentist/owner) working minimum hours/week	
3 Less: Number of employees waiving coverage because covered by spouse	-
4 Net eligible employees	
5 Less: Number of employees waiving coverage and not covered by spouse	-
6 Number of employees enrolling	

9. **Waiting Period for New Employees:** _____ months (All new employees have a 30 day waiting period.)

Coverage begins on the first day of a given month, After the end of the Waiting Period.

10. **Employer contribution toward premiums:** _____ Employee _____ Dependent(s)

Contribution may be expressed as a flat dollar amount or percentage, per month.

11. **Name of Previous Group Insurance Company/Administrator:** _____ **No Previous Carrier:** ____

Please attach a copy of most recent billing statement from previous carrier (if applicable).

DENTIST(S)

Plan Type: PPO ____ HSA ____

Deductible: $_____

Requested Initial Effective Date: _____/_____/_____

EMPLOYEE(S)

Plan Type: PPO ____ HSA ____

Deductible: $_____

Signatures below illustrate an understanding that the IDA plan is being offered based upon information provided to Anthem BCBS. Group rates quoted are valid until renewal (January 1) and will be adjusted, if necessary, each year. Anthem reserves the right to re-rate the group if the number of employees enrolling listed on this form changes by more than 10% within 31 days after the effective date.
The signatures below confirm acceptance of all information and coverage named and selected in this document.

_____ _____/_____/_____
Insurance Contact – SIGNATURE Date

_____
Insurance Contact – PLEASE PRINT

_____ _____/_____/_____
IDA Insurance – SIGNATURE Date

_____
IDA Insurance – PLEASE PRINT

UNDERWRITING ACTION

Effective Date: _____ Risk Class: _____ Acct #: _____

Date of Underwriting Action: _____ Underwriter's Initials: _____

Please initial below to confirm group's acceptance of final offer, then fax or mail this form to IDA Insurance, who will then forward to the underwriter, within ten (10) business days of the Date of Underwriting Action. This confirmation finalizes all information above. No changes will be accepted until renewal (January 1).
Dentist or Insurance Contact's Initials: _____ IDA Initials: _____