



Application for Dental Insurance

Dental Plan # 430806

Employer Name _____

Employer Address _____

City _____ State _____ Zip Code _____ Phone Number _____

Employer Contact Name _____

- Effective Date (Must be the first of the month) _____
- Total # Eligible Employees _____
- # Participating Employees _____
- Employee eligibility waiting period _____
- # of hours worked weekly to be eligible for dental insurance _____

Insurance Broker Name / Agency _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Select One of the Following Plan Sizes and Plan Designs:

2-9 EMPLOYEES – (Based on number of employees enrolled under the plan.)

HSA Compatible 100/50/25 Traditional 100/80/50

10-99 EMPLOYEES – (Based on number of employees enrolled under the plan.)

HSA Compatible 100/50/25 Traditional 100/80/50

Orthodontia Rider included? Yes No

Contributory (75% Participation) Yes No

Voluntary Yes No

Participation load applied to rates - _____ %

Does the employer have a dental plan for their Employees Now? Yes No

(If employer has dental insurance immediately prior to the effective date of the BRS dental plan please submit copy of most recent billing statement.)

Who is the dental carrier now? _____

What is the termination date of the existing dental plan? _____

Sold Dental Rates: # EMPLOYEES

RATES

Employee: \$ _____

EE+1: \$ _____

Family: \$ _____

BRS Administration Fee Yes (Groups w/ 10 or more employees - \$10/Month) No

Signed by insurance broker _____ Date _____

Signed by member employer _____ Title _____ Date _____

- Attach Enrollment Forms and deposit check for first month premium made payable to BRS.
- Please submit completed paperwork 15 days prior to the effective date of the plan.

FOR BRS USE ONLY

BRS Member Number _____

Class Assignment _____