DentalNOW![sm] PRODUCER DATA SHEET

1\. a. Name of Group | Key Contact:

b. Billing Address (if different from Group Application) including zip code

c. Telephone Number | d. Group's Contract Situs State (if other than mailing state)

e. What is the nature of their business? | f. What is the Group's Benefit Eligibility Waiting Period?

g. Does the Group have a Section 125 Plan? ☐ Yes ☐ No   If yes, what is the Group's designated month of enrollment?

h. Is the Group replacing a prior dental insurance plan? ☐ Yes ☐ No

If yes, prior Carrier Name ____________________ Original Effective Date __________ DHMO plan? ☐ Yes ☐ No

2. Plans Selected

Note: Choose Executive, Deluxe *or* Secure *and/or* Basic; choice options are limited to a maximum of two plans, one of which must be Basic.

________ **Executive**   ________ **Deluxe**   ________ **Secure**   ________**Basic**

3. Participation Requirements

a. Number of Enrolled Employees (from Enrollment Forms) ________
b. Number of Employees With Spousal Waivers ________
c. Total Counted Towards Participation (3a + 3b) ________
d. Number of Eligible Employees ________
e. Participation Rate (3c/3d) ________%

Note: If the Basic Plan is sold as a standalone and 75 plus participants enroll, participation requirements will be waived.

4. Rate and Enrollment Information

	Executive	Deluxe	Secure	Basic
a. **Rates Quoted**				
Ee only	______	______	______	______
Ee + 1	______	______	______	______
Family	______	______	______	______
b. **No. of Employee Lives Enrolled**				
Ee only	______	______	______	______
Ee + 1	______	______	______	______
Family	______	______	______	______

5. Estimating First Month's Premium (4a x 4b):

	Executive	Deluxe	Secure	Basic	Total
Ee only	______	______	______	______	
Ee + 1	______	______	______	______	
Family	______	______	______	______	*
Total	══════	══════	══════	══════	══════

*The Employer's check in this amount, made payable to the Administrator, must be submitted for processing.

6. Producer Information

Name ______________________________ Telephone Number (______)______________________

Are you appointed with BCS Insurance Company? ☐ Yes ☐ No If yes, when? ____/____/____ If no, complete and return the Agent Appointment Information Form

Are you affiliated with a firm? ☐ Yes ☐ No If yes, firm's license number ____________________

Send policy, certs and ID cards to: ☐ Me ☐ Policyholder ☐ Other ______________________________

I certify that all information on this Data Sheet is correct to the best of my knowledge. I have fully explained the **DentalNOW!** Program to the applicant and further certify that eligible employees were provided with the appropriate **DentalNOW!** Plan Description(s).

Signature of Producer ______________________________ Date __________

DentalNOW! Group Dental Insurance Plans

Administrator: ASRM, LLC
509 South Lenola Road, Building 2
Moorestown, NJ 08057
1-856-231-9100