

# REQUEST FOR DentalNOW! GROUP DENTAL INSURANCE



1. Name of Employer \_\_\_\_\_

2. Address \_\_\_\_\_

3. Telephone Number (\_\_\_\_) \_\_\_\_\_

4. Key Contact \_\_\_\_\_ Title \_\_\_\_\_

5. Indicate Plan(s) Selected: \_\_\_Executive \_\_\_Deluxe \_\_\_Secure \_\_\_Basic

6. Desired Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

7. Description of Eligible Employees: \_\_\_\_\_

\_\_\_\_\_

**If offering the BASIC Plan, you must list occupation(s) here:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Benefit Eligibility Waiting Period \_\_\_\_\_

9. Do you have a Section 125 Plan? \_\_\_Yes \_\_\_No

If Yes, which month will you designate for open enrollment? \_\_\_\_\_

10. Are you replacing a prior group dental insurance plan? \_\_\_Yes \_\_\_No

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Title \_\_\_\_\_