

Employer Agreement and Application



P.O. Box 19721
Irvine, CA 92623-9721
1-877-247-6778

Employer		Employer Tax I.D. Number																																																		
Address		City	County	State Zip																																																
Billing address (if different from above)		Type of business																																																		
Phone number	Fax number	Email address		Requested effective date																																																
Name and title of person to whom billing is directed		No. of years in same location		No. of years in business																																																
PREMIUM CONTRIBUTION BY EMPLOYER: Employee _____% Dependent _____% (Plan is considered Employer Paid if the employer contributes at least 50% of the employee's premium or 50% of the employee and dependents' combined premium. If contribution is less than 50%, the plan is considered Voluntary.)		WAITING PERIOD FOR ELIGIBLE EMPLOYEES – New employees are eligible for coverage on the first of the month after satisfying one of the following employee waiting periods. <input type="checkbox"/> First of the month following date of hire <input type="checkbox"/> First of the month following introductory period of 30/60/90 days. (circle one) <input type="checkbox"/> Other (please specify): _____																																																		
Will this replace any existing insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, name of previous carrier (include copy of billing & policy)																																																			
No. of years with previous carrier	Date of termination	No. of eligible employees	No. of employees applying for coverage																																																	
Is employer required to offer COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, list number of participants																																																		
BEST Health Plans Advantage DHMO <table border="1"> <thead> <tr> <th></th> <th>Employer Sponsored</th> <th>Voluntary</th> <th>4-Tier</th> <th>3-Tier</th> <th>Rate</th> <th># Enrolled</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td>EE</td> <td>EE</td> <td>\$ _____ x _____</td> <td></td> <td>= \$ _____</td> </tr> <tr> <td></td> <td></td> <td></td> <td>EE + Spouse</td> <td>EE +1</td> <td>\$ _____ x _____</td> <td></td> <td>= \$ _____</td> </tr> <tr> <td>Advantage Plan G191</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>EE + Child (ren)¹</td> <td></td> <td>\$ _____ x _____</td> <td></td> <td>= \$ _____</td> </tr> <tr> <td>Advantage Plan G192</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family</td> <td>EE +2</td> <td>\$ _____ x _____</td> <td></td> <td>= \$ _____</td> </tr> <tr> <td>Advantage Plan G301</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">Total DHMO Monthly Premium</td> <td></td> <td></td> <td>= \$ _____</td> </tr> </tbody> </table>						Employer Sponsored	Voluntary	4-Tier	3-Tier	Rate	# Enrolled	Total				EE	EE	\$ _____ x _____		= \$ _____				EE + Spouse	EE +1	\$ _____ x _____		= \$ _____	Advantage Plan G191	<input type="checkbox"/>	<input type="checkbox"/>	EE + Child (ren) ¹		\$ _____ x _____		= \$ _____	Advantage Plan G192	<input type="checkbox"/>	<input type="checkbox"/>	Family	EE +2	\$ _____ x _____		= \$ _____	Advantage Plan G301	<input type="checkbox"/>	<input type="checkbox"/>	Total DHMO Monthly Premium				= \$ _____
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Advantage Plan G301	<input type="checkbox"/>	<input type="checkbox"/>	Total DHMO Monthly Premium				= \$ _____																																													
Total Combined Monthly Premium \$ _____		SEE BELOW FOR AGREEMENT																																																		
First Month's Remittance \$ _____		Make checks payable to: BEST Health Plans																																																		

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

- I understand that only regular, full-time, active employees, partners and proprietors, working a minimum of 20 hours per week and their eligible dependents are eligible for coverage. I understand the pre-existing conditions limitations of the plan, and understand that coverage is renewable at the option of the offering company.
- I understand the underwriting and participation requirements, and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The open enrollment period shall be during group's 11th month of annual continuous coverage.
- The Employer Agreement and Application, the first month's premium check, and employee information must be received in our office no later than the 25th of the month prior to the requested effective date. Coverage shall become effective on the first day of the following month. All employees will be billed monthly with premiums due by the last day of the month preceding coverage.
- Enrollment applications for new hires must be received by the last day of the month in order to reflect on the next month's billing invoice.
- Employers will not be eligible to participate in the plan if the number of eligible employees drops below two. A notice of termination will be sent to the employer unless the plan receives notification that another employee has been hired before the next premium due date.
- The BEST Health Plans Advantage DHMO Plans are offered by Dental Benefit Providers of California, Inc. ("DBP-CA").

Signature of authorized person _____ Date signed _____

Print name of authorized person _____ Title _____

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge, I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Broker or General Agent signature _____ Date _____

Print name of Broker or General Agent _____ Agent # _____

Address (street, city, state, zip) _____ Phone # _____

E-mail address _____ Fax # _____

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

¹Disregard the "EE + Child(ren)" line if a 3-tiered rate is selected.