

MWG DENTAL CHECK LIST
For Initial Enrollment

1. _____ **COMMISSION SPLIT ATTACHED IF MORE THAN ONE AGENT INVOLVED.**
2. _____ **GROUP APPLICATION: MUST BE COMPLETE. STATE SPECIFIC, IF NECESSARY(AR, CA, CO, District of Columbia, FL,GA, IL, KY, LA, MD, NJ, NM, NY, OH, OK, OR, PA, SC, TN)**

Required information:

1. **Group Standard Industry Code (SIC) Code** - highlighted above the MWG Logo on 1st page
 2. E-mail address for contact person. If not available please note and highlight.
 3. Tax ID number
 4. Prior Carrier Information completed, if takeover group.
 5. Requested Effective Date
 6. Sold Rates for Group
 7. Physical Address (must have for ID Card)
 8. **Group Signature** and Date
 9. Agent Signature and Date
3. _____ **DENTAL CARRIER CHANGE FORM: IF GROUP IS A TAKEOVER IF SIMPLIFIED ENROLLMENT AND TAKEOVER THIS FORM IS NOT REQUIRED BECAUSE INCLUDED IN SIMPLIFIED ENROLLMENT NOTIFICATION FORM.**
4. _____ **SIMPLIFIED ENROLLMENT NOTIFICATION FORM IF GROUP IS DOING SIMPLIFIED ENROLLMENT WITH NO APPLICATIONS**
5. _____ **PRIOR CARRIER BILL IF GROUP IS TAKEOVER**
6. _____ **COPY OF PROPOSAL**
7. _____ **EMPLOYEE ENROLLMENT**

A. COMPLETE EMPLOYEE ENROLLMENT FORM

B. WE WILL PROVIDE PREPRINT APPLICATION FOR GROUPS OVER 50

Required Information:

1. Social Security Number
2. Employee First and Last Name
3. Address including City, State, Zip
4. Sex (Male or Female)
5. Date of Birth
6. Dependent information – to include Name, Date of Birth, Relationship And Sex
7. Vision Enrollment if available - Mark and elect plan coverage if different from Dental coverage.
8. Employee Signature

C. SIMPLIFIED ENROLLMENT – BY EMAIL OR DISC IN AN EXCEL SPREADSHEET – IN SEPARATE FIELDS

1. Primary Insured - Social Security Number, Last Name, First Name, Sex, Date of Birth, Address, City, State, Zip
2. Dependents – Last Name, First Name, Date of Birth, Sex, Relationship

Employer Application

Group Dental Coverage

Provided by United HealthCare Insurance Company



Company Name:		
Address:		City:
State:	Zip Code:	Phone Number:
Fax Number:		Contact Name:
E-Mail Address of Contact:		

EMPLOYER INFORMATION

Organization Type: Corporation Partnership Sole Proprietor Political Subdivision¹ Other
¹Submit legal opinion or minutes from Board Meeting along with application showing consent.

Full Legal Name of Employer:
 Include names of subsidiaries or affiliated companies

Employer Identification Number (Tax ID):	Subject to ERISA? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your firm ever filed for or is it in the process of filing for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DENTAL PLAN PARTICIPATION AND SELECTION

Did the group have dental coverage for the past [12] months? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of prior dental carrier:
Requested effective date of coverage: ___/___/____ All effective dates must be first of the month.	
Total number of employees on payroll:	Total number of full time/eligible employees (EE):
Multi Site: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Locations: _____
Locations: _____	
Number of COBRA participants in total group:	Number of Retirees in total group:

Dental Plan Selected:

Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	EE				
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

Amount of Binder Check:
 ***This check must accompany the group application.

BILLING AND CONTACT INFORMATION

Please provide the information below if different than above for billing purposes and plan administration.

Address		
City:	State:	Zip Code:
Contact Name:	Phone:	
Fax:	E-Mail Address:	

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of [31] days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the group policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage for a period of two years after the Effective Date of the Policy.

I agree that the company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

Authorized Officer's Name:	Title:
Authorized Officer's Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date:
Agent Number:	

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS

NAME _____	PHONE (____) _____
ADDRESS _____	CITY _____ ST _____ ZIP _____

FINANCIAL INSTITUTION _____
CITY, STATE, ZIP _____

**PLEASE ATTACH A VOIDED BLANK CHECK
(REQUIRED FOR PROCESSING)**

I hereby authorize the Financial Institution named above to pay my monthly obligation by charging each payment to my account and to make that deduction payable to the order of Morgan White Administrators, Inc. (MWA). I agree that each payment shall be the same as if it were an instrument personally signed by me. This authorization will remain in effect until revoked by me in writing. In addition I have the right to stop payment of a charge by timely notification to my Financial Institution prior to charging my account. I understand, however, that both the Financial Institution and Morgan White Administrators, Inc. reserve the right to terminate this payment plan (or my participation therein). By signing below I agree to the following terms:

1. Payments will be posted on the 1st of each month and Morgan White Administrators, Inc. should receive any changes prior to this date.
2. I understand that payments will debit my account between the 1st and 5th of each month, Delta Dental will debit my account between the 18th and 23rd of each month for the upcoming month.
3. Morgan White Administrators, Inc. will post insurance rate increases to my account without requiring additional authorization.
4. Payments not honored will not be submitted a second time.
5. Morgan White Administrators, Inc. will send notice of payment not honored.
6. If a payment is not honored my insurance terminates 15 days after notice has been sent.
7. If I wish to continue my insurance after a payment is not honored, Morgan White Administrators, Inc. prior to the end of that month must receive full payment.
8. If I wish to continue my insurance after a payment is not honored, Morgan White Administrator, Inc. will charge a \$30 fee in addition to any bank charges.
9. Reinstatement is only possible within 60 days of the not honored payment after that no reinstatement is possible.
10. After two (2) payments are not honored, reinstated is not possible.

_____ X _____
DATE PLEASE SIGN AS YOU SIGN CHECKS

NOTE: Please return this authorization and a *VOIDED CHECK* to:

Matrix Insurance Marketing, Inc 1225 So. Weller St., Suite 320 Seattle, WA 98144 Phone: 206.521.9451 Fax: 206.521.9554
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DRAFT CAN NOT BE PROCESSED WITHOUT A VOIDED ORIGINAL CHECK.
DEPOSIT SLIPS ARE NOT ACCEPTABLE!

Company use only: Group _____ I.D. # _____

Amount \$ _____ Draft Date ____/____/____

Requirement for a Domestic partner

A Domestic Partner must submit the required documentation listed on the Domestic Partners Amendment regardless of whether or not he/she had prior coverage.

The Subscriber and Domestic Partner of the Subscriber must meet the requirements listed on the Domestic Partners Amendment and they are required to submit at least three of the following documents evidencing financial interdependence:

1. have a single dedicated relationship of at least 6 months duration
2. joint ownership of residence
3. at least two of the following:
 - joint ownership of an automobile
 - joint checking, bank or investment account;
 - joint credit account
 - lease for a residence indentifying both partners as tenants
4. a will and/or life insurance policies which designates the other as primary beneficiary

The Subscriber and Domestic Partner must submit at least three of the above documents.

If they choose #3 as one of their three choices of documentation, then they must submit at least two of the items requested from that list.