

# NEW BUSINESS SUBMISSION FORM

## Agent Information

### NEW BUSINESS SUBMISSION CHECKLIST

Please make sure the following is submitted with **all** new cases. We cannot process a case without all of the following information:

- \_\_\_ Completed Employer Application
- \_\_\_ Completed Employee Enrollments
- \_\_\_ 1<sup>st</sup> Month Premium (Payable to: MNL)
- \_\_\_ Section 125 Plan Verification, if any
- \_\_\_ Producer Licensing Forms (if not previously submitted)
- \_\_\_ Verification of Eligibility Form
- \_\_\_ Copy of Quoted Rates
- \_\_\_ Completed Submission Form

### TAKE OVER CREDIT CASES

Please make sure **all** of the following information is enclosed on all prior coverage take over cases:

- \_\_\_ Copy of prior plan schedule of benefits and rates
- \_\_\_ Copy of prior plan's last billing listing each employee covered.

**\*\*Prior credit is available only to Employees enrolled on the initial effective date of the plan and approved by IHC Health Solutions.**

### GUIDELINES AND PROCEDURES

1. All coverage will be effective on the first of the month, except when necessary for takeover cases. All groups with initial effective dates other than the 1<sup>st</sup> of the month will be converted to the 1<sup>st</sup> of the month and will become the anniversary date.
2. Voluntary Groups. Payroll deductions should begin 4-6 weeks prior to effective date in order to satisfy premium prior to the effective date.
3. In no event will claims be paid prior to the effective date *and* the date group setup is complete.
4. Applications, premium and enrollment forms must be received **before** the requested effective date month.
5. Upon receipt of *complete* documentation, IHC Health Solutions will assign a group number and issue an administration folder to the Employer. I.D. cards and certificates will follow.

**6. Please submit new cases to the following:**

**Physical Address:** 1225 S Weller St, Suite 320, Seattle, WA 98144

**Email:** [info@matrixinsurance.com](mailto:info@matrixinsurance.com)

**Fax:** 206-521-9554



# NEW BUSINESS SUBMISSION FORM

## Policy Administration Information

The following information needs to be completed in order to assist IHC Health Solutions in administering your dental plan. Please place a check mark in the appropriate box or circle where indicated.

Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer E-mail Address: \_\_\_\_\_

Agent E-mail Address: \_\_\_\_\_

### INITIAL ENROLLMENT PROCESS

**Employer wishes to submit initial enrollments as follows (check one):**

- Electronic enrollment via excel spreadsheet.  
 Submit hardcopy enrollments to **IHC Health Solutions** or **Agent** (circle one) (IHC HS to provide forms).

### ONGOING ENROLLMENT PROCESS

**Employer wishes to submit ongoing enrollments as follows (check one):**

- Online enrollment via the Internet (IHC Health Solutions will advise password).  
 Submit hardcopy enrollments to **IHC Health Solutions** or **Agent** (circle one) (IHC HS to provide forms).

### ADMINISTRATION KITS (WELCOME TO IHC HEALTH SOLUTIONS)

**IHC Health Solutions to forward the Administration Kit and Instruction Guide as follows (check or circle as indicated):**

- Send via the Internet to Agent or Employer (circle one).  
(above information will be E-mailed within 2 business days of receipt of completed requirements)  
 Send hardcopy directly to **Agent** or **Employer** (circle one).

### DENTAL INSURANCE POLICY AND CERTIFICATES

**IHC Health Solutions to forward the Policy and Certificates as follows (check or circle as indicated):**

- Send via the Internet to Agent or Employer (circle one).  
(above information will be E-mailed within 5 - 15 working days of receipt of all completed requirements)  
 Send hardcopy directly to **Agent** or **Employer** (circle one).

**Note:** Based on Insurance Regulations, it is required that the Employer provides the Insurance Certificates to the Employees either as a hardcopy or through online access.

The undersigned acknowledges the above instructions and understands the importance of providing the Employees the Insurance Certificates immediately upon receipt.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date





**DENTAL PREMIUM / MONTHLY COST**

**Select one tier structure: Employee Plan Option A**

- Composite rate: \$ \_\_\_\_\_
- Two tier rates: Single: \$ \_\_\_\_\_ Family: \$ \_\_\_\_\_
- Three tier rates: Single: \$ \_\_\_\_\_ EE& One Dependent: \$ \_\_\_\_\_ Family: \$ \_\_\_\_\_
- Four tier rates: Single \$ \_\_\_\_\_ EE&Spouse \$ \_\_\_\_\_ EE/Child(ren): \$ \_\_\_\_\_ Family: \$ \_\_\_\_\_
- Five tier rates: Single: \$ \_\_\_\_\_ EE&Spouse: \$ \_\_\_\_\_ EE& 1 Child: \$ \_\_\_\_\_ EE&Children: \$ \_\_\_\_\_ Family: \$ \_\_\_\_\_
- Five tier rates: Single \$ \_\_\_\_\_ EE&Spouse \$ \_\_\_\_\_ EE& 1 Child \$ \_\_\_\_\_ EE&2 or 3 deps \$ \_\_\_\_\_ EE&4or more deps \$ \_\_\_\_\_

Will the employees be required to contribute toward the cost of the insurance?  Yes  No

If yes, indicate the percentage of the cost of each coverage the employee will pay.

Coverage	EE Dental	Dep Dental	STD
Employee % or Dollar amount			

Note: If the employer pays the entire cost for the **employees**, then 100% of the eligible employees **must** apply for coverage.

**DENTAL COVERAGE INFORMATION**

**Employee Plan Option A:** \_\_\_\_\_

	<b>Benefit Waiting Period</b>	<b>Deductible Amount per Person (check one)</b>	<b>Select One</b>	
			<input type="checkbox"/> <b>Non-PPO Coinsurance Percentage</b>	<input type="checkbox"/> <b>PPO Coinsurance Percentage In Network/Out of Network</b>
Preventive Care	_____	<input type="checkbox"/> Annual <input type="checkbox"/> Lifetime	_____	_____
Diagnostic Care	_____	_____	_____	_____
Basic Care	_____	_____	_____	_____
Major Care	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____

Office Visit Co-pay: \$ \_\_\_\_\_  
 Other Co-pays \$ \_\_\_\_\_ Applied to: \_\_\_\_\_

Dental Maximum (except ortho) Calendar Year  Plan Year  Amount \_\_\_\_\_  
 Orthodontics  Yes  No If Yes, Calendar Year Limit \$ \_\_\_\_\_ Lifetime Maximum \$ \_\_\_\_\_  
 Dental PPO  Yes  No Network \_\_\_\_\_

**Optional Benefits (additional premium may be required)**

- Coverage for Implants (this box needs to be checked and additional premium paid to add this coverage)  Yes
- Cosmetic Procedures (this box needs to be checked and additional premium paid to add this coverage)  Yes
- Posterior Composites (this box needs to be checked and additional premium paid to add this coverage)  Yes
- Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage)  Yes
- Temporomandibular Joint (TMJ) Disorders  Yes



# Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number \_\_\_\_\_  
 Group Number \_\_\_\_\_
2. Total number of employees on payroll \_\_\_\_\_
3. Total number of employees working 1-29 hours per week (include temporary and/or seasonal employees) \_\_\_\_\_
4. Total number of employees in waiting period \_\_\_\_\_
5. Number of full-time eligible employees (subtract numbers 3 and 4 from number 2) \_\_\_\_\_

If you have purchased an employee paid voluntary group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above. No waivers for coverage under another program will be allowed in this calculation.

For employer paid group coverage (with rates calculated from a census), the number of employees listed in number 6 and 7 below may be subtracted from the number of full time employees shown in number 5 above. Participation requirements will be calculated from that number.

6. Total number of employees enrolled in a DHMO or qualified Discount/Referral plan (proof must be submitted) \_\_\_\_\_
7. Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file) \_\_\_\_\_
8. Number of eligible employees (subtract 6 & 7 from 5) \_\_\_\_\_
9. Number of full-time employees enrolled \_\_\_\_\_
10. Premium information: \_\_\_\_\_ 100% employer paid **OR** employer pays \_\_\_\_\_% of employee premium and \_\_\_\_\_% of dependent premium.

### Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by IHC Health Solutions, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

Signature of Writing Agent \_\_\_\_\_ Agent Code \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Type or Print Agent's Name(s) \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Agent's Business Address (City, State & Zip Code) \_\_\_\_\_

Title \_\_\_\_\_

Agency \_\_\_\_\_ Agency Code \_\_\_\_\_

Company Name \_\_\_\_\_

Send all completed forms to:  
 Matrix Insurance Marketing, Inc.  
 1225 So. Weller St., Suite 320  
 Seattle, WA 98144  
 Phone: 206.521.9451 / Fax: 206.521.9554  
 Email: info@matrixinsurance.com



**MADISON NATIONAL LIFE INSURANCE COMPANY, INC.****EMPLOYEE DENTAL INSURANCE APPLICATION**

Send all completed forms to:  
 Matrix Insurance Marketing, Inc.  
 1225 So. Weller St., Suite 320  
 Seattle, WA 98144  
 Phone: 206.521.9451 / Fax: 206.521.9554  
 Email: info@matrixinsurance.com

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER INFORMATION					
EMPLOYER NAME			LOCATION		GROUP NO.
EMPLOYEE					
LAST NAME		FIRST NAME			M.I.
STREET ADDRESS		CITY	STATE		ZIP
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ( )			BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
COVERAGE – Check Those That Apply (Note: If declining coverage(s), complete the section REFUSAL/WAIVER only)					
Dental Insurance			Requested Effective Date: _____		
<input type="checkbox"/> EMPLOYEE		<input type="checkbox"/> SPOUSE		<input type="checkbox"/> CHILDREN	
			Plan Name Elected: _____		

DEPENDENT INFORMATION			
SPOUSE NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: _____			

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent
I DECLINE DENTAL COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILDREN
REASON FOR REFUSAL: _____

ACKNOWLEDGMENT AND AUTHORIZATION
I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.
WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
DATE
CITY AND STATE
SIGNATURE OF EMPLOYEE