

NEW GROUP SUBMISSION CHECKLIST

Please confirm that the following information is submitted with all new cases:

- Completed Employer Application**
 - Complete entire application and be sure to pay close attention to fields marked in **YELLOW**
 - Company email address
 - Employer AND agent MUST sign and date application

- Completed Employee Application**
 - Complete entire application and be sure to pay close attention to fields marked in **YELLOW**
 - Social Security Number
 - Birthdate
 - Marital Status
 - If adding Domestic Partner as dependent you MUST submit completed and signed Domestic Partner Form
 - Employee MUST sign and date application

- Waivers are needed if group does not meet participation requirements without valid waivers.**

- First Month Premium (Payable to Employer Plan Services, Inc.)**

- Copy of Quote**

- Producer Licensing Forms (if not previously contracted)**

Take Over Benefit Coverage

(Must provide the following documentation if group was enrolled with a prior carrier)

- Copy of Prior Plan's Schedule of Benefits and Rates**
- Copy of Prior Carrier's Most Recent Billing Statement**

Please submit all completed and signed paperwork to:

Matrix Insurance Marketing, Inc.
1225 So. Weller St., Suite 320
Seattle, WA 98144
Phone: 206.521.9451
Fax: 206.521.9554

Important Information

***New group applications should be postmarked no later than the 30th of the month to be effective by the first of the following month.**

Employer Application

Group Dental Coverage

Provided by United HealthCare Insurance Company

CONFIDENTIALSM
by cbg

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? Yes No

Has your firm ever filed for or is it in the process of filing for bankruptcy? Yes No

DENTAL PLAN PARTICIPATION AND SELECTION

Did the group have dental coverage for the past [12] months? Yes 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: Yes 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+ Spouse				
	EE+ Child(ren)				
	Family				

Amount of Binder Check:

***This check must accompany the group application. Add \$15.00 Admin Fee to Binder Check.

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.

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:
Agency Name:	
General Agency Name: Matrix Insurance Marketing, Inc	



AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, _____ and I, _____
Print Employee's Name Print Domestic Partner's Name

DECLARE UNDER PENALTY OF PERJURY THAT WE ARE DOMESTIC PARTNERS WITHIN THE MEANING OF THE FOLLOWING DECLARATION:

1. We have chosen to share one another's lives in an intimate and committed relationship of mutual caring and intend to remain domestic partners indefinitely;
2. We share the same principal residence and have shared the same principal residence for six (6) months;
3. We agree to be jointly responsible for each other's basic living expenses during our domestic partnership, such as food, shelter or medical expenses; we also agree that we share financial obligations and any third-party who is owed these expenses can collect from either of us;
4. We are both at least 18 years of age;
5. Neither of us is married or a member of another domestic partnership;
6. Neither of us is related by blood to the other, such as parent, brother, sister, half-brother or -sister, niece, nephew, aunt, uncle, grandparent or grandchild; and
7. Neither of us has had a different Domestic Partner or spouse in the last six (6) months, unless a previous domestic partnership or marriage terminated by death.

The Employee agrees to immediately notify his or her employer's Human Resources department in writing if there is any change of circumstances attested to in this Affidavit.

Each of us understands that the company may be required to report imputed income to an eligible employee who has enrolled a Domestic Partner for coverage under this Plan, if the partner does not qualify as a dependent of the employee as that term is defined by Section 152(a) of the Internal Revenue Code.

Each of us understands that the non-employee Domestic Partner and his/her dependents do **not** have rights to continuing coverage under federal law through COBRA.

Each of us understands the rules of the plan and declares under penalty of perjury that the statements we have made here are true and correct.

Employee's Signature

Date

Domestic Partner's Signature

Date