Momentum Insurance Plans, Inc.
2971 Chapel Valley Road
Madison, WI 53711
Ph: (608) 729-6500
www.momentumplans.com

Group Number (for internal use only):

Group Dental Insurance Application
Wisconsin

REQUESTED EFFECTIVE DATE _____/_____/_____ (Must be 1st of month) **CONTRACT PERIOD** _____/_____/_____ **TO** _____/_____/_____

SECTION 1: GROUP INFORMATION (Please print clearly, using black ink)

Legal Name of Employer	DBA (if different)		
Physical Address	City	State	Zip
Mailing Address (if different from physical address)	City	State	Zip

Nature of Business			Type of Business: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Non-Profit ☐ Other ___________
Years in Business	SIC Code	Employer Identification Number (EIN)	

Contact	Email Address	Telephone ( ) -	Fax ( ) -

Billing Contact (Primary)	Email Address		
Billing Address	City	State	Zip
Telephone ( ) -	Fax ( ) -		

Billing Delivery Method: ☐ E-mail ☐ Paper ☐ Fax

Form 5500 required? ☐ Yes ☐ No | Plan Year : to

Print ID Cards with: ☐ Social Security Number (SSN) ☐ Alternative Identification Number (other than SSN)

Print Correspondence/reports with: ☐ Social Security Number (SSN) ☐ Alternative Identification Number (other than SSN)

If Alternative Identification Number is checked above, the number will be assigned by: ☐ Group ☐ Momentum Insurance Plans, Inc.

SECTION 2: MONTHLY RATES & EMPLOYER CONTRIBUTIONS (*60% minimum participation required for groups of more than 10 eligible employees. For groups of 10 eligible employees, 6 must enroll, for groups of 8 or 9 eligible employees, 5 must enroll, for groups of 7 eligible employees, 4 must enroll, for groups of 5 or 6 eligible employees, 3 must enroll, and for groups of 2-4 eligible employees, 2 must enroll)

Total Number of Eligible Employees:	Total Number of Enrolled Employees:*		Domestic partner coverage? ☐ Yes ☐ No	
Employer Contribution (Minimum 25%)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family

SECTION 3: PLAN DESIGN

New Hire Waiting Period

Indicate the time period employees must wait before they become eligible for dental insurance

☐ Date of hire
☐ 1st of the month following ____ days
☐ 1st of the month following ____ months

Open enrollment: ☐ Annual ☐ None ☐ Other – please describe:

Coverage termination date for employees/dependents: ☐ Date of termination ☐ End of month following termination ☐ Other (describe) _______________

Will this coverage replace any existing dental insurance plan? ☐ Yes ☐ If yes, please provide the following:

Name of present dental insurance carrier: ________________________________ Existing Plan Effective Date: ______/______/______

Termination Date of Existing Plan: ______/______/______ Coverages being replaced: ☐ Preventative ☐ Basic ☐ Major ☐ Orthodontia

SECTION 3: PLAN DESIGN (continued)

Is prior insurance credit (takeover benefits) requested? ☐ Yes ☐ No

The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to effective date.

- Evidence that the prior carrier's coverage has been in force for at least 12 months.
- A copy of the most recent bill which includes a listing of all covered employees.
- A list of the covered employees with the prior carrier which includes the employee's effective dates of coverage.
- A copy of the existing dental plan which may be a contract, certificate, or booklet.

Are other dental plans offered? ☐ Yes ☐ No If yes, please describe:

Current Health Carrier:	Address:
Plan Administration: ☐ Fully Insured ☐ Self-funded	Premium Remittance: ☐ ACH ☐ Check

Diagnostic & Preventative Services:	☐ 100%	☐ 80%	☐ 50%	☐ Other ________%	☐ No coverage	
Basic Services:	☐ 100%	☐ 80%	☐ 50%	☐ Other ________%	☐ No coverage	
Major Services:	☐ 100%	☐ 80%	☐ 50%	☐ Other ________%	☐ No coverage	
Waiting period (major services)?	☐ Yes ☐ No	Duration ☐ days/months				
Orthodontia Services:	☐ 100%	☐ 80%	☐ 50%	☐ Other ________%	☐ No coverage	
Waiting period (orthodontia)?	☐ Yes ☐ No	Duration ☐ days/months				
Annual Maximum:	☐ $2,000	☐ $1,500	☐ $1,000	☐ $500	☐ Other $_______	
Orthodontic Maximum:	☐ $2,000	☐ $1,500	☐ $1,000	☐ $500	☐ Other $_______	☐ No coverage
Deductible:	☐ None	☐ $25/$75		☐ $50/$150	☐ Other ________	
Endo/Perio/Oral Surgery:	☐ Covered under basic services	☐ Covered under major services			☐ None	

SECTION 4: VERIFICATION

By signing below, I certify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may be come null and void at the option of Momentum Insurance Plans, Inc. if for a period of three consecutive months, or upon renewal, the number of enolled employees becomes less than two.

Momentum Insurance Plans, Inc. will return a contract upon acceptance of the application. The contract will indicate the effective date of coverage. The contract is effective only after Momentum Insurance Plans, Inc. has accepted this application and sent a contract to the group. The group's administrator's signature does not cause the application to become effective as a contract. Any misrepresentations or submitted data will cause the contract, if issued, to be null and void at the option of Momentum Insurance Plans, Inc.

Signature of Authorized Company Official	Title	Date
Group Administrator/Future Correspondence Contact (please print)	Title	
Phone Number ( ) -	Fax Number ( ) -	E-mail Address

SECTION 5: AGENT INFORMATION (if applicable)

Agent/Broker Name:	Agency Name:		
Address:	City:	State:	Zipcode:
Phone:	License No:	Social Security No/EIN:	E-mail:
Agent Signature:			Date:

Momentum Insurance Plans, Inc. is unable to accept this document with any changes, cross-outs, white-outs, etc. unless the person signing the application or the agent of record initials those changes. Both sides of form must be completed. Approval of coverage is contingent upon underwriting acceptance.