

NEW YORK APPLICATION FOR EMPLOYER DENTAL BENEFITS POLICY

Please print or type New Policy Change in Policy Policy No. _____ Requested Effective Date _____

SECTION 1: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number:

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3. Main Address: _____
STREET CITY STATE ZIP CODE COUNTY

Mailing Address (Billing): _____
STREET CITY STATE ZIP CODE

Telephone:

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 Facsimile:

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4. Name of Company Official: _____ Title: _____

5. Type of Organization: Corporation Partnership Proprietorship Other (explain): _____

6. Nature of Business (specify): _____ SIC Code: _____

7. Number of eligible employees in your company: _____ 8. Number of eligible employees to be insured: _____
(Eligible employees are those who work at least 25 hrs. per week)

9. Class or classes to be excluded: _____

10. Insurance requested for: Employees Only Employees and Dependents

11. Are you subject to the requirements of COBRA? Yes No

12. Waiting period before new/rehired employees become insured: (may not exceed 6 months) Present: _____ New: _____

13. What percentage of the premium will the employer pay? _____ 14. Deposit \$ _____

Premium Paid: Monthly Quarterly Automatic checking withdrawal

The premium for the first month of coverage must be attached.

Premium will be due as of the effective date.

SECTION 2: SPECIFICATION OF COVERAGE (Dental Benefits Selection)

1. Horizon Dental Option 3. Horizon Dental PPO Access
2. Horizon Dental PPO 4. Other

SECTION 3: PLAN

Horizon Healthcare Insurance Company of New York

SECTION 4: ALL QUESTIONS MUST BE ANSWERED

a. Name of present or prior group carrier _____

Effective date of prior coverage _____ Cancellation/Termination Date _____

Is the coverage applied for in this application replacing other group insurance? Yes No

If "Yes", give reason _____

Please attach copy of the prior carrier bill received in last 90 days.

b. Has your firm been uninsured for 3 or more months prior to application? Yes No

SECTION 5: SIGNATURE

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of any of the companies identified in Section 3 ("Horizon Healthcare") to make or modify any request or application for insurance or to bind Horizon Healthcare by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Healthcare. No contract of insurance is to be implied in any way on the basis of the completion and or submission of this application.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

Print name of Officer, Partner, or Owner

Signature of Officer, Partner, or Owner

Witness to Signature

Dated at _____ on _____

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

FRAUD WARNING: Any person who knowingly and with intent to fraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AGENT/PRODUCER INFORMATION (THIS INFORMATION MUST BE ANSWERED COMPLETELY)

_____	_____	_____
BROKER SIGNATURE	DATE	VENDOR NUMBER
BROKER-NAME	NAME OF AGENCY	TELEPHONE NUMBER
STREET	CITY	STATE ZIP CODE
OTHERS (NAME, TITLE)		
SPECIAL INSTRUCTIONS		

FOR INTERNAL GROUP DENTAL ENROLLMENT USE

Coverage Code	c/o													
TOTAL APPLICATIONS SUBMITTED														
TRANSFER FROM GROUP # _____														
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)														
EMPLOYER CONTRIBUTION														
EFFECTIVE DATE														
FUTURE RATE RENEWAL DATE														
<table style="width:100%; margin-top: 20px;"> <tr> <td style="width:50%; text-align:center; vertical-align:bottom;">_____</td> <td style="width:20%; text-align:center; vertical-align:bottom;">_____</td> <td style="width:30%; text-align:center; vertical-align:bottom;">_____</td> </tr> <tr> <td style="text-align:center;">SALES ASSOCIATE SIGNATURE</td> <td style="text-align:center;">DATE</td> <td style="text-align:center;">ITEM NUMBER</td> </tr> <tr> <td>APPROVED BY: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="text-align:center;">SALES ADMINISTRATION SIGNATURE</td> <td style="text-align:center;">TITLE</td> <td style="text-align:center;">DATE</td> </tr> </table>			_____	_____	_____	SALES ASSOCIATE SIGNATURE	DATE	ITEM NUMBER	APPROVED BY: _____	_____	_____	SALES ADMINISTRATION SIGNATURE	TITLE	DATE
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