



Group Voluntary Dental Insurance Employer Election Form

Please complete all of the information on page 1 and 2 and return to the BIAW Health Insurance Program.

Employer Information

Legal Name of Employer			
Employer Number	Requested Effective Date	SIC/NAICS Code	
Street Address	City	State	Zip
Group Contact (Name and Title):			
Mailing Address	City	State	Zip
Phone Number ()	Fax Number ()	Email Address	

Plan Information

Participation: Total number of Eligible Employees _____ Number to be insured for Vol Dental _____
The Plan(s) selected will cover: <input type="checkbox"/> Employees Only <input type="checkbox"/> Employees and Dependents
Employer Contribution: Employee _____% Dependents _____%
Eligible Classes: Active work means: The Employee is working for the Employer on a regular and active basis for at least the minimum number of hours stated below, is receiving regular Earnings from the Employer; and is employed at the Employer's usual place of business or at a location to which the Employer's business requires the Employee to travel. <input type="checkbox"/> All full-time active Employees <input type="checkbox"/> Management <input type="checkbox"/> Non Management <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Other _____ working the Minimum hours (17.5 – 40) of _____
New Employee Waiting Period: New full-time employees are eligible for coverage the first of the month following your group's waiting period. <input type="checkbox"/> None <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> Other _____
Do you wish to waive the new employee waiting period for existing employees at initial enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to include non-state registered domestic partners for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No

Select ONE of the following Dental Plan Options

STANDARD DENTAL PLAN

ENHANCED DENTAL PLAN

Group Insurance Trust Monthly Payment Requirements:

Detailed monthly billing statements for the next month's premium are sent out to all companies before the end of each month. The Trust's "Contractual" PAYMENT DUE DATE is the first day of the billed month.

In order to maintain CURRENT ELIGIBILITY for employees, full payment must be received by the Trust on or before the 15th day of the billed month. A company's eligibility for the month will be DELINQUENT if full payment is not received by the 15th. DELINQUENT ELIGIBILITY STATUS results in claim payment delays, and other difficulties involving employees, their providers and carriers.

If full payment for the month is not received within 30 days of the PAYMENT DUE DATE, company will be RETROACTIVELY CANCELLED back to the last day of the month in which full monthly payment was received. Partial payments will be refunded.

Payments returned to the Administrator (for any reason) must be replaced with guaranteed funds (i.e. Cashier's check, money order, cash) within 5 working days of being notified by the Administrator. A \$20 fee will be assessed on all returned drafts.

Agreement: I have read and understand this entire application. The information provided is accurate to the best of my knowledge. I understand that I have a duty to notify LifeMap Assurance Company™ of any changes. It is understood and agreed that no insurance shall be effective until approved by the LifeMap Assurance Company at its Home Office.

Disclosure: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from. Incentives may be based on any of several factors including the size of group business, the products you buy, your broker or agent's volume of business with LifeMap Assurance Company™ and the other services your agent or broker provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your broker or agent.

Insurance Fraud 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
Name and Title of Authorized Group Administrator (please print)

▶ _____ Dated at (City, State)
Signature of Group Administrator