Small Group Employer
Agreement and Application

PacifiCare®
Dental & Vision Administrators

Sales Department LC05-206
3110 Lake Center Drive
Santa Ana, CA 92704
Fax 714-513-6381 • 800-516-4680

Group Number	PacifiCare SignatureValue[SM] (HMO) Dental	PacifiCare SignatureIndependence[SM] (Indemnity) Dental	PacifiCare SignatureOptions[SM] (PPO) Dental	PacifiCare SignatureOptions[SM] (PPO) Vision

Employer | Employer Tax ID Number

Address | City | County | State | Zip

Billing address **(if different from above)** | Type of business

Phone number | Fax number | Email address | Requested effective date

Name and title of person to whom billing is directed | No. of years in same location | No. of years in business

Minimum premium contribution by employer: 50% of the employee's premium or 50% of the employee's and the dependent's combined premium.

Employee ________% Dependent ________%

WAITING PERIOD FOR ELIGIBLE EMPLOYEES – New employees are eligible for coverage on the first of the month after satisfying one of the following employee waiting periods.
- ☐ First of the month following date of hire
- ☐ First of the month following introductory period of 30/60/90 days. **(circle one)**
- ☐ Other **(please specify):** ____________________

Will this replace any existing insurance coverage? ☐ No ☐ Yes | If yes, name of previous carrier **(include copy of billing & policy)**

No. of years with previous carrier | Date of termination | No. of eligible employees | No. of employees applying for coverage

Is employer required to offer COBRA? If yes, list number of COBRA participants. ☐ No ☐ Yes

Is employer required to offer Cal-COBRA? If yes, list number of Cal-COBRA participants. ☐ No ☐ Yes

PacifiCare SignatureOptions Dental Plan[1]

☐ **Dental 400**	☐ **Dental 410**	☐ **Dental 420**	☐ **Dental 460**	☐ **Other**
80/80	100/80	100/100	100/70	____/____
80/50	80/50	80/60	NA	____/____
50/50	50/50	60/40	NA	____/____

VOLUNTARY PLAN ☐ **Dental 310** ☐ **Dental 312** ☐ **Dental 460**

MAX COVERAGE ☐ $1,000 ☐ $1,500 ☐ Other

DEDUCTIBLE ☐ $50 Individual/$150 Family In-Network, $100 Individual/$300 Family Out-of-Network
☐ Other ____________________

REIMBURSEMENT ☒ Fee Schedule

☐ **COST MANAGEMENT OPTION** – Endodontic, Periodontic & Oral Surgery covered in Major Services (Required for voluntary plans)

4-TIER	**RATE**	**# ENROLLED**	**TOTAL**
EE	$ ________	x ________	= $________
EE + Spouse	$ ________	x ________	= $________
EE + Child(ren)	$ ________	x ________	= $________
Family	$ ________	x ________	= $________

Total PacifiCare SignatureOptions Monthly Premium = $ ________

PacifiCare SignatureIndependence Dental Plan[1]

☐ **Dental 800**	☐ **Dental 810**	☐ **Dental 820**	☐ **Dental 830**	☐ **Other** ________
80/80/50	00/80/50	80/80/50	100/80/50	
($1,000 MAX)	($1,000 MAX)	($1,500 MAX)	($1,500 MAX)	

DEDUCTIBLE ☐ $50 Individual/$150 Family ☐ Other ________

4-TIER	**RATE**	**# ENROLLED**	**TOTAL**
EE	$ ________	x ________	= $ ________
EE + Spouse	$ ________	x ________	= $ ________
EE + Child(ren)	$ ________	x ________	= $ ________
Family	$ ________	x ________	= $ ________

Total PacifiCare SignatureIndependence Monthly Premium = $ ________

PacifiCare SignatureValue Dental Plan

☐ **Dental 140** ☐ **Dental 142** ☐ **Dental 144**

VOLUNTARY ☐ Above plan as Voluntary

4-TIER	**RATE**	**# ENROLLED**	**TOTAL**
EE	$ ________	x ________	= $ ________
EE + Spouse	$ ________	x ________	= $ ________
EE + Child(ren)	$ ________	x ________	= $ ________
Family	$ ________	x ________	= $ ________

Total PacifiCare SignatureValue Monthly Premium = $ ________

PacifiCare SignatureOptions Vision Plan[1]

☐ **Vision 480 (Eyewear Only)** ☐ **Vision 490 (Full Service)**

EXAM DEDUCTIBLE ☒ None

MATERIAL DEDUCTIBLE ☒ None

VISION 480 PLAN

4-TIER	**RATE**	**# ENROLLED**	**TOTAL**
EE	$ ________	x ________	= $ ________
EE + Spouse	$ ________	x ________	= $ ________
EE + Child(ren)	$ ________	x ________	= $ ________
Family	$ ________	x ________	= $ ________

Total Vision 480 Monthly Premium = $ ________

VISION 490 PLAN

4-TIER	**RATE**	**# ENROLLED**	**TOTAL**
EE	$ ________	x ________	= $ ________
EE + Spouse	$ ________	x ________	= $ ________
EE + Child(ren)	$ ________	x ________	= $ ________
Family	$ ________	x ________	= $ ________

Total Vision 490 Monthly Premium = $ ________

Total PacifiCare SignatureOptions Vision Monthly Premium = $ ________

Total Combined Monthly Premium $ ________
First Month's Remittance $ ________

SEE OTHER SIDE FOR AGREEMENT
Make checks payable to: PACIFICARE DENTAL & VISION ADMINISTRATORS

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWINGLY THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

[1]Underwritten by PacifiCare Life & Health Insurance Company, Inc

1. I understand that only regular, full-time, active employees, partners and proprietors, working a minimum of 20 hours per week and their eligible dependents are eligible for coverage. I understand the pre-existing conditions limitations of the insurance plan, and understand that coverage is renewable at the option of the Underwriting Company.

2. I understand the underwriting and participation requirements, and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force. The open enrollment period shall be during group 's 11th month of annual continuous coverage.

3. The Employer Agreement and Application, the first month's premium check, and employee information must be received in our office no later than the 25th of the month prior to the requested effective date. Insurance coverage shall become effective on the first day of the following month. All employees will be billed monthly with premiums due by the last day of the month preceding coverage.

4. Enrollment applications for new hires must be received by the last day of the month in order to reflect on the next month's billing invoice.

5. **For the PacifiCare SignatureIndependence Plan and the PacifiCare SignatureOptionsPlan, I understand that there is a one-year waiting period for "Major" dental services depending on the group plan. "Major" dental services include either crowns, dentures and bridges OR crowns, dentures, bridges, oral surgery, periodontics, and endodontics. This waiting period will be waived for employees/dependents listed on the prior carrier's billing at the time of transfer to a PacifiCare SignatureIndependence or PacifiCare SignatureOptions plan. New hires are subject to a one-year waiting period for all "Major" dental services.**

6. Employers will not be eligible to participate in the plan if the number of eligible employees drops below two. A notice of termination will be sent to the employer unless the plan receives notification that another employee has been hired before the next premium due date.

7. The PacifiCare SignatureIndependence and PacifiCare SignatureOptions Dental, and PacifiCare SignatureOptions Vision plans are underwritten by PacifiCare Life and Health Insurance Company.

8. The PacifiCare SignatureValue Dental Plans are offered by PacifiCare Dental.

For the PacifiCare SignatureIndependence plans only:

The undersigned employer hereby adopts and enrolls in the group insurance plan of the Vanguard Group Dental Trust and subscribes to the terms of the Trust agreement which established such Trust. It is understood that no coverage is in force until notice of approval has been furnished by the Trust Administrator and premium has been received by the Trust Administrator.

I further acknowledge and agree that no one other than the Trustees or a person designated in writing by the Trustees may accept this application on behalf of the Vanguard Group Dental Plan Trust,and that no agent or broker has the authority to change any provision of the master policy or of the trust.

Signature of authorized person ______________________________ Date signed ______________

Print name of authorized person______________________________ Title______________

I hereby certify that all of the information contained in the agreement and application is correct to the best of my knowledge, I have complied with the underwriting rules and have explained to the applicant in detail the coverages of this plan. Any exceptions are detailed here or on an additional sheet attached.

Broker or General Agent signature ______________________________ Date ______________

Print name of Broker or General Agent ______________________________ Agent #______________

Address (street, city, state, zip) ______________________________ Phone # ______________

E-mail address ______________________________ Fax #______________

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.