

EMPLOYER APPLICATION

For Employers With 51 Employees or More

Hawaii Dental Service
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 HawaiiDentalService.com
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Phone: (808) 529-9206
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GROUP INFORMATION

Desired Start Date *(HDS will confirm and advise of start date upon acceptance)*: _____

Full Legal Name of Group *(The business must be registered and in good standing with the Hawaii State Department of Commerce and Consumer Affairs)*: _____

Federal Identification Number (FIN): _____ - _____ (Required)

DOL Unemployment Insurance ID#: _____ (Required)

Type of Business: _____ SIC Industry Code: _____

Is this a national company? Yes No

Does the company contribute to the employees' dental premiums? Yes No

Total Number of W-2 Employees: _____ Number of Eligible Employees*: _____ Number of Employees Enrolling: _____

**An Eligible Employee is an employee who works on a full-time basis with a normal workweek of 20 hours or more.*

(Check and Complete all that Apply)	Full-Time Employees	Dependents of Full-Time Employees	Part-Time Employees	Dependents of Part-Time Employees	Retirees	Dependents of Retirees
Members Eligible for Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employer Contribution (% or \$)						

What conditions are tied to the dental plan offering? For example, does an employee need to enroll in a medical plan to get dental or is dental packaged with other benefits like drug or vision? Do you have a probationary period for dental plans?

Current Dental Carrier: _____ Current Medical Carrier: _____

Dental Rate History	Number of Subscribers	RATES		
		Current Year	Last Year	2 Years Prior
One Party				
Two Party				
Three Party+				

If additional rate tiers apply, please submit a separate rate sheet.

Please provide the following:

- 1) Summary of Current Dental Benefits, Brochure or Summary of Benefits
- 2) Utilization/Experience Reports
- 3) Group Census

CONTACTS

Group Administrator (The individual responsible for the overall administration of the plan.)

Mr. Ms. Dr. First Name: _____ Last Name: _____
Title: _____ Company: _____
Telephone: _____ ext. _____ Fax: _____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____

Executive Contact: CEO, President, Owner, etc.

Check here if this contact is the same person as Group Administrator. If so, there is no need to fill out the contact information.

Mr. Ms. Dr. First Name: _____ Last Name: _____
Title: _____ Company: _____
Telephone: _____ ext. _____ Fax: _____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____

Billing Contact: the individual who should receive the bill

Check here if this contact is the same person as Group Administrator. If so, there is no need to fill out the contact information.

Mr. Ms. Dr. First Name: _____ Last Name: _____
Title: _____ Company: _____
Telephone: _____ ext. _____ Fax: _____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____

Eligibility Contact: the individual responsible for eligibility and enrollment

Check here if this contact is also the Group Administrator. If so, there is no need to fill out the contact information.

Mr. Ms. Dr. First Name: _____ Last Name: _____

Title: _____ Company: _____

Telephone: _____ ext. _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

IRS FORM 5500 SCHEDULE A

Does the group need information to complete an IRS Form 5500? Yes No

If yes, please complete this section.

Fiscal Year Start: _____ Fiscal Year End: _____

IRS Form 5500 Contact: The individual should receive the IRS Form 5500 Schedule A information.

Check here if this contact is the same person as Group Administrator. If so, there is no need to fill out the contact information.

Mr. Ms. Dr. First Name: _____ Last Name: _____

Title: _____ Company: _____

Telephone: _____ ext. _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

BROKER

Do you use a broker? Yes No *If yes, please attach a Broker of Record letter and complete the information below.*

Mr. Ms. Dr. First Name: _____ Last Name: _____

Title: _____ Company: _____

Telephone: _____ ext. _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Hawaii Insurance Producer License Number: _____

COBRA

Employer groups who offer COBRA dental benefits are responsible for compliance with the COBRA regulations. Detailed COBRA regulations and procedures should be obtained from the Department of Labor or through consultation with your legal counsel. Every employer group plan that provides COBRA should have a Plan Administrator. The Plan Administrator is responsible for ensuring that COBRA regulations are adhered to, proper COBRA documentation is maintained and required notifications are provided on a timely basis. HDS does not serve as the COBRA Plan Administrator. HDS may assist the Plan Administrator with the collection of monthly premiums and payment/eligibility notifications to COBRA subscribers.

Will COBRA be offered? Yes No If yes, please answer the question below.

Will HDS collect COBRA premiums directly from the group's subscribers? Yes No

TERMS AND CONDITIONS

Completion and submission of this application constitutes agreement to be bound by the following terms and conditions at all times during the quoting process: You represent, warrant, and agree that (i) you are legally authorized to submit the application information; (ii) if submitting this agreement electronically, you consent to the use of electronic signatures or acknowledgements as valid and legally binding; (iii) your participation in this process complies with all applicable laws including the Health Information Portability and Accountability Act, and a Business Associate Agreement is in place if required; (iv) submitted information is complete and accurate, and you will promptly notify HDS of any changes; (v) HDS is relying on, and has no obligation to audit or verify, the information submitted; and (vi) you are legally authorized to receive the information requested. YOU AGREE TO INDEMNIFY AND HOLD HARMLESS HAWAII DENTAL SERVICE AGAINST ANY CLAIM OR LIABILITY ARISING OUT OF, RELATED TO, OR IN CONNECTION WITH, YOUR SUBMISSION OF THIS APPLICATION AND RECEIPT OF THE REQUESTED INFORMATION, INCLUDING THE SUBSEQUENT USE OR DISCLOSURE OF SUCH INFORMATION.

Approval (Employer) Signature

Title

Date