EMPLOYER APPLICATION

For Employers With 51 Employees or More

Hawaii Dental Service
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Honolulu, Hawaii 96813
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Phone: (808) 529-9206
1-844-502-1989
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1-866-376-7600

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 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	☐	☐	☐	☐	☐	☐
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 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: _____

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 provide assistance to 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

ACKNOWLEDGEMENT

The employer/applicant hereby represents and warrants that the individuals designated herein as representatives are duly authorized to act on behalf of the employer/applicant with respect to all matters pertaining to this group dental plan. The employer/applicant acknowledges that HDS is relying upon the statements and information provided or incorporated by reference in this application for the plan. The employer/applicant hereby represents and warrants that all such statements and information are true, correct and complete as of the date of the Employer Application, and hereby agrees that it shall promptly notify HDS in writing of any changes in such statements and information.

Approval (Employer) Signature

Title

Date