Employer Application
Group Dental Coverage

Company Name:	Date Created:	
Address:	DBA (if applicable):	
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Primary Contact Name:	E-Mail Address of Contact:	

EMPLOYER INFORMATION

Organization Type: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other: ________________________

Full Legal Name of Employer:
(Include names of subsidiaries or affiliated companies)

Are any divisions billed to a different location? ☐ Yes ☐ No
If yes, please provide contact name and addresses.

Employer Identification Number (Tax ID):

Has your firm ever filed for or is it in the process of filing for bankruptcy? ☐ Yes ☐ No

DENTAL PLAN PARTICIPATION AND SELECTION

Dental Plan Name (Code):

Did the group have dental coverage for the past 12 months? ☐ Yes ☐ No	If yes, name of prior dental carrier:

CONTRACT INFORMATION

Coverage Begins:	Employee Eligibility:	Coverage Ends:	Dependent Age Limits:
☐ Date of Hire 1st of the month following: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 Months ☐ Other	☐ Min. 30 Hrs/Wk ☐ Other ________________	☐ End of month of termination ☐ Date of termination ☐ Other__________________	☐ 19/25 ☐ Other __________

Total number of employees on payroll:	Total number of full time/eligible employees (EE):
Number of COBRA participants in total group:	Number of Retirees in total group:

Rates and Contributions

	Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Single Tier	EE				
Two Tier	EE				
	Family				
Three Tier	EE				
	EE+ One				
	Family				
Four Tier	EE				
	EE+ One				
	EE+ Child(ren)				
	Family				

BILLING AND ADMINISTRATIVE CONTACT INFORMATION
Please provide the information below if different than above for billing purposes and plan administration.

BILLING CONTACT

Contact Name:	Contact Title:	
Address:	E-Mail Address:	
City:	State:	Zip Code:
Phone:	Fax:	

AGENT/BROKER VERIFICATION

BROKER INFORMATION

Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name:	Address:	
City:	State:	Zip Code:
E-Mail Address:	Phone:	Fax::

GENERAL AGENT INFORMATION

Agent/Broker Name:	Tax ID#:	% Commission:
Agency Name: ARMS Insurance Group	Address: 3000 Lento Boulevard	
City: Bethel Park	State: PA	Zip Code: 15102
E-Mail Address: trionda@ARMSins.com	Phone: 412.835.9100	Fax:: 412.831.8667

SIGNATURE SECTION
I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is taken on this application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this application is declined, the Company will return the premium deposit submitted with the application. If my coverage is approved, premium is payable monthly in advance.

I understand and agree that failure to pay premium when due will be considered a default in premium payment, and that the Company will terminate coverage following a grace period (time extension for payment of premium) of 31 days from the date of nonpayment of premium. If the coverage is terminated by the Company for nonpayment of premium, I will still owe, and the insurance company will collect, premium, for the grace period. I understand that coverage may also be terminated for other reasons as provided in the policy.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which coverage will be made effective. I understand that the material omissions or misrepresentations could result in voiding or reformation of coverage.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of newly eligible employees or dependents.

Pennsylvania
"Any person who knowingly and with intent to defraud 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 subjects such person to criminal and civil penalties."

Authorized Officer's Name:	Title:
Authorized Officer's Signature:	Date:
Agent Name:	Date:
Agent Signature:	Date: