

**EMPLOYER AGREEMENT
DENTAL DIRECT**

(Please type or Print)

SECTION 1. EMPLOYER INFORMATION

Employer Name: _____
(Provide Complete Legal Name)

FEIN: _____
(Federal Employer Identification Number)

Employer Type: Corporation S-Corporation Partnership
(Select One) Professional Assoc. LLC Other _____

Location Address _____ Mailing Address (If different from Location Address) _____

(City, State, Zip)

Contact Person _____ Telephone Number: () _____ - _____
(Name, Title)
FAX Number: () _____ - _____ E-Mail Address: _____

SECTION 2. DENTAL ENROLLMENT INFORMATION

Plan A Plan B Plan C Plan D F (Other)

Proposed Effective Date _____ Prior Carrier (if any) _____

Probationary Period 0 days 30 days 60 days 90 days
Effective the 1st of the subsequent month following Probationary Period completion

Employer Contributions (of employee cost): _____ Employer Contribution (of dependent cost)
 minimum 25% Other none other %

Number of Employees _____

Please note: Dental Direct customers must comply with all HIPAA requirements.

I hereby certify that the information contained herein is complete and accurate to the best of my knowledge and belief. I understand that any misrepresentations or false statements will subject any issued coverage to immediate termination.

Signed _____ Date _____
(Authorized Representative of Employer)

Dental Direct Plans

PLAN A

Reimburse 80% of the first \$250 of dental expense
50% of the next \$1,600
Maximum Annual Benefit: \$1,000

PLAN B

Reimburse 100% of the first \$250 of dental expenses
50% of the next \$1,500
Maximum Annual Benefit: \$1,000

PLAN C

Reimburse 75% of the first \$1,000 of dental expenses
50% of the next \$1,500
Maximum Annual Benefit: \$1,500

PLAN D

Reimburse 50% of \$1,000 of dental expenses
Maximum Annual Benefit \$500

PLAN F

Will be available for groups that want to custom build their own plan.