# EMPLOYER GROUP APPLICATION

Please send to: newgroups@cypressadmin.com

Cypress Dental Insurance Company
of California
7510 Shoreline Drive
Stockton, California 95219
Phone 800-350-3989

## EMPLOYER INFORMATION

| | | | |
|---|---|---|---|
| **Group No.** (internal) **:** | | **Effective Date:** | |
| Legal Name of Group: | | **SIC Code:** | |
| Street Address: | | | |
| City: | | State: | Zip: |
| Phone: ( ) | Fax: ( ) | Federal Employer ID: | |
| Main Contact Name: | | | |
| Phone: ( ) | Fax: ( ) | E-mail Address: | |
| Billing Contact Name *(if different from above):* | | | |
| Phone: ( ) | Fax: ( ) | E-mail Address: | |
| Billing Street Address *(if different from above):* | | | |
| City: | | State: | Zip: |
| Employer Portal Contact Name *(if different from above):* | | | |
| Phone: ( ) | Fax: ( ) | E-mail Address: | |

**Plan Selection:** We elect to offer the following coverages to our Employees (see attached benefit summary for details) :

| **Dental** | **Vision** | **Life / Disability** |
|---|---|---|
| ❑ PPO / Hybrid | ❑ MESVision | ❑ Life |
| ❑ CYPRESS DHMO | ❑ Superior | ❑ LTD |
| ❑ LIBERTY DHMO | | ❑ STD |

How are you purchasing your dental benefits: ❑ Stand Alone ❑ Dual Option ❑ Triple Option

Total number of employees: _____ Number of employees not eligible: _____
*(Part-time, in waiting period, terminations, etc.)*

Number of employees eligible: _____ Number of employees participating: _____

## ELIGIBILITY

**CATEGORIES OF ELIGIBILITY** *(Subject to Cypress's approval)*:

❑ **Actively-at-Work Employees** (employees scheduled to work at least _____ hours per week.)
A bona-fide employee/employer relationship is required to be maintained, i.e. the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g., FICA, FUI, SUI and Worker's Compensation) normally associated with a bona-fide employee relationship. Generally, employees must be actively at work before coverage commences. Any other eligibility arrangements require prior approval from Cypress.

- Employees are eligible to continue group coverage for _____ month(s) while on an Employer approved temporary personal leave of absence *(maximum of 6 months).*
- Employees are eligible to continue group coverage for _____ month(s) while on an Employer approved medical leave of absence *(maximum of 6 months).*

❑ Are Domestic Partners covered under this Plan ❑ Yes ❑ No

❑ Dependent Children Covered to Age 26

❑ Other _____

*All references to "Cypress" herein refer to Cypress Dental Insurance Company of California

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**CATEGORIES NOT ELIGIBLE (EXCLUDED)**

❑ Part-time Employees (employees scheduled to work less than _____ hours per week.)

❑ Other *(please specify)* _____

**ELIGIBILITY WAIT PERIOD / EFFECTIVE DATE FOR EMPLOYEES**

*Eligibility Wait Period must be satisfied before an Employee becomes Eligible for coverage.*

Existing Employees must be employed Full-time with the Employer for _____ ❑ days ❑ months ❑ hours.

New Employees must be employed Full-time with the Employer for _____ ❑ days ❑ months ❑ hours.

## BENEFIT PLAN AND PREMIUM

*Please attach a copy of the original proposal document issued by Cypress that lists the plan provisions and rates for the plan you are choosing.*

**FIRST MONTH'S PREMIUM** Check attached in the amount of $ _____

**BENEFIT PLAN OPTION** (e.g., $1000 Cal Max Plan UCR, $1500 Cal Max MAC Plan) _____

**COVERAGE RIDERS** ❑ None ❑ Orthodontia ❑ TMJ ❑ Other: _____
❑ Max Roll Forward ❑ Preventive Rewards ❑ Implants

**EMPLOYER CONTRIBUTION**

Employee Only $ _____ or _____ % of Cypress premiums/fees.

Dependents $ _____ or _____ % of Cypress premiums/fees.

**PRIOR COVERAGE**

The Applicant has prior dental coverage for Employees: ❑ No ❑ Yes

If Yes, please complete the following: Carrier Name: _____

Policy Number: _____

Carrier Phone Number: _____

# COBRA

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## COBRA

The Applicant is subject to (check one): ❑ Federal COBRA (more than 20 employees) ❑ Cal-COBRA (up to 20 employees)

Does the Applicant currently have COBRA or Cal-COBRA enrollees? ❑ Yes ❑ No
(*If yes, please attach a list including name(s) and original effective date(s) of COBRA coverage and a copy of COBRA election statement.)*

**Please specify the manner in which COBRA Premiums will be billed for your company if you are subject to Federal COBRA. (Note that Cal - COBRA is always billed to the COBRA member.)**

❑ COBRA members will submit premiums directly to the employer group. Cypress will bill the group for all COBRA premiums

❑ COBRA members will submit premiums directly to a Third Party Administrator (TPA). Cypress will bill the TPA for all COBRA premiums. Please specify the name and address of TPA below.

Name: _____

Address: _____

## EMPLOYER STATEMENT OF UNDERSTANDING

This application shall be the basis for the issuance of coverage under the Policy and Certificate and shall become a part thereof. Cypress reserves the right to terminate group coverage or the coverage of any individual Covered Person if the contract holder or individual Covered Person has made any material misrepresentation.

**PAYMENT OF PREMIUMS AND/OR FEES:** Premiums and/or fees are due on the first day of each month for which coverage is provided. Delinquent payments shall be subject to late charges of $20 per month. If payment is not received from the Employer, coverage for all Covered Persons will be terminated on the last day of the month for which premium payment was received. Termination of coverage, including cancellation due to nonpayment of premium, may be applied retroactively. Any other payment arrangements require prior approval by Cypress. Claims for covered services shall not be paid until the premium payment for the month of service has been received. If a Covered Person receives dental services after coverage is terminated or lapses, the Covered Person is responsible to reimburse Cypress for any payments made by Cypress for such services.

**VERIFICATION OF ELIGIBILITY:** Verification of eligibility does not guarantee payment of claims. Retroactive eligibility changes supercede verifications of eligibility.

**CHANGES IN PARTICIPATION OR PREMIUM PERCENTAGES:** Coverage and premiums are based, in part, on the number of Covered Persons, the percentage of Employees and Dependents participating and the percentage of premium paid by the Employer. If any of these fall below levels accepted by Cypress or below the level upon which the premium has been based, Cypress may terminate the coverage by giving notice to the Employer. Additionally, if misrepresented in the application, the employer is responsible for any resulting losses incurred by Cypress.

**MANDATORY BINDING ARBITRATION:** As more fully set out in the Policy and Certificate, we agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the Policy. By enrolling in this plan, Employer and Covered Persons waive their constitutional right to a trial before a jury or judge. Any dispute alleging the malpractice, negligence and/or wrongful act of a provider, shall not include Cypress and shall include only the provider subject to the allegation.

*I certify that all the information contained in this application is correct to the best of my knowledge and all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees. I certify that I have read, understand and concur with the provisions of the Employer Statement of Understanding above.*

Dated at _____ this _____ day of _____, 20_____

Print Name and Title _____

Authorized Employer Signature *(must be an officer)* _____

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## Application Check List

- ❑ **Employer Application**: The application should be completed and signed by the client and the broker.
- ❑ **Employee Applications and Waivers** : An enrollment application or waiver form from all employees eligible for coverage must be included.
- ❑ **Proposal document**: A copy of the original proposal document issued by Cypress that lists the plan provisions and rates for the benefit plan you are choosing.
- ❑ **Deposit**: A check from the employer that will be applied to the first month's premium must be included.
- ❑ **Prior Carrier's Billing Statement** : A copy of the most recent billing statement from the prior carrier, if there is prior coverage, must be included.
- ❑ **COBRA Information**: A list of all former employees/dependents on COBRA which includes the qualifying reason and qualifying date of COBRA coverage plus a copy of the COBRA election statement(s) must be included.
- ❑ **State Wage and Tax Withholding Statement (DE-9C in CA)**: For groups with 50 or fewer eligible employees, a copy of the employer's most recent quarterly statement is required. (Required for groups without prior dental coverage only).

## BROKER INFORMATION

**BROKER STATEMENT:**

I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the applicant is a bona-fide business establishment. I certify all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined. I understand that no agent has power on behalf of Cypress to make or modify any request or application for insurance, or to bind Cypress by making any promise or representation or by giving or receiving any information. I further understand that no insurance will be effective until Cypress accepts the Employer group in writing. No contract of insurance is to be implied in any way on the basis of the completion and submission of this application.

Dated at _____ this _____ day of _____, 20_____

Broker Name: _____

Agency Name: _____

Broker Phone: _____

Broker Email: _____

Federal Tax Identification Number: _____